because of its usefulness in predicting beliefs that one can cope effectively in a variety of stressful situations. General self-efficacy theorists suggest that personal expectations and differences in perceived successful experiences are a major factor in behavioral change and can be discerned through different levels of generalized self-efficacy expectations (Sherer & Maddux, 1982).

The German version of this scale was originally developed by Jerusalem and Schwarzer in 1981 as a 20-item instrument and subsequently reduced to a 10-item version in 1992. Since its development the scale has been used in several research studies where it yielded estimates of internal consistency ranging from alpha =.75 to .90. Evidence of convergent and discriminate validity was provided by strong positive correlations with measures of similar constructs of optimism and positive self-esteem and was negatively correlated with measures of depression and anxiety (Schwarzer & Jerusalem, 2000). Bilingual native speakers adapted the English and German versions of the ten self-efficacy items in 13 other languages. The first English sample consisted of 219 arthritis patients in Great Britain, the second English sample was with 290 Canadian university students, and the third English sample was composed of 1,437 website respondees 15-25 years old, 78% of whom were from North America. Item analyses were performed separately for each scaled adaptation. The internal consistency estimates derived from Cronbach's alpha were satisfactory with the highest reported at .91 for the Japanese version and the lowest reported at .78 for the Greek version; the English version was .90. Unidimensionality and homogeneity of each scale was established through one-factor solutions and multigroup confirmatory factor analysis such as chi-square, root mean square residuals, and various goodness of fit indices (Schwarzer, 1997).

Role Breadth Self-Efficacy

Measurement of the independent variable, role breadth self-efficacy, was measured by the Role Breadth Self-Efficacy (RBSE) measure (Appendix D). This instrument was selected because of its innovative approach towards the role expansion of employees within modern organizations. Nursing literature suggests that involving families in patient care requires initiative, determination, and an expansion of one's role (Courtney, R., Ballard, E., Fauver, S., Gariota, M., & Holland, L., 1996; Robinson, 1996; Wright & Leahey, 1999). Parker's (1998) goal in developing this scale was to "represent important exemplar elements of an expanded role that apply across jobs and hierarchical levels." Furthermore, she proposed in two separate field studies "organizational interventions such as job enrichment, work redesign practices, and job related training *enhanced* the employees' perception of role breadth self-efficacy, and contributed to employees' sense of control and increased mastery experiences" (Parker, 1998).

She tested the validity of her instrument by using a confirmatory factor analysis with RBSE, and two related constructs, self-esteem, and proactive personality as a three-factor model and reported factor-loading estimates for all of the items as significant at the .001 level, with standardized coefficients greater than .45. Further evidence of the scale's validity was achieved from a one-way analysis of variance between professional and nonprofessional employees that showed there were significant differences in proactive and integrative work skills ($F= 44.18$, $p<.001$), and a planned comparison showed that nonprofessional employees had significantly lower RBSE scores than professional employees ($t=7.21$, $p<.001$) (Parker, 1998).

Since this measure asks the respondent to evaluate beliefs conducive to a

ASSESSING STAFF NURSES' STYLES OF INVOLVEMENT WITH THE FAMILIES OF THEIR PATIENTS

By

CATHY M. BURNS

A DISSERTATION PRESENTED TO THE GRADUATE SCHOOL
OF THE UNIVERSITY OF FLORIDA IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

UNIVERSITY OF FLORIDA

2002

This dissertation is dedicated in loving memory to my husband, Richard R. Burns. His faith and love supported me throughout this process. The bravery and determination he showed during his fight against cancer will always be an inspiration to me.

ACKNOWLEDGMENTS

I would like to extend my sincere appreciation to Dr. Ellen Amatea, chair of my committee, who guided me through this process with patience, enthusiasm, and skill. She set an example of caring that I will always remember and her unfailing instinct for just the right phrase is a testament to her intelligence and grace. My sincere thanks go to Dr. David Miller and Dr. Silvia E-Doan, each of whom contributed their unique expertise to refine my understanding of the research process. Additionally I am grateful to Dr. Lovetta Smith for her friendship throughout these many years; her astute observations and enduring calmness always helped to make the most difficult concepts understandable.

Several people have been a part of my journey towards achieving this goal. First and foremost, my mother Chrissy and my sister Colleen, both of whom have traveled down this same road, inspired me time and again through their confidence that I could accomplish this lifelong ambition. My sister-in-law, Debbie, who daily required a report of my progress, helped to bolster my determination to finish. I also received invaluable support when I most needed it from my colleagues at work Mary Ann, Sherri, and Jen and thank them for putting up with my anxieties and always telling me to just "get on with it!"

Finally, I thank and bless my two children, Shane and Erin, and their spouses, Michelle and Brian, who cheered me on through this process. Their love and faith in me have enriched my life and sustained me through the ups and downs as I aspired to make my dream a reality.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

Abstract of Dissertation Presented to the Graduate School
of the University of Florida in Partial Fulfillment of the
Requirements for the Degree of Doctor of Philosophy

ASSESSING STAFF NURSES' STYLES OF INVOLVEMENT WITH THE FAMILIES OF THEIR PATIENTS

By

Cathy M. Burns

December, 2002

Chair: Ellen Amatea, Ph.D.
Major Department: Counselor Education

This study, based on the three theoretical frameworks social role theory, self-efficacy theory, and theories of family health care, assessed the self-perception factors and individual characteristics influencing staff nurses' style of involvement with patients' families. Regression analyses explored the prediction of staff nurses' preference for individual focused patient care versus family focused patient care from indicators of family self-efficacy, general self-efficacy, role breadth self-efficacy, perceptions of organizational support, and individual demographic characteristics. Results from the multiple regression analyses of data from a sample of 353 registered nurses employed full-time in a staff level hospital inpatient position revealed that family self-efficacy in combination with role breadth self-efficacy, perceptions of organizational support, and general self-efficacy accounted for a significant amount of the variance in reported preferences for family focused patient care (35%). Interestingly, contrary to prior family nursing studies, individual characteristics such as age, marital status, nursing specialty,

years of nursing experience, level of oursing education, and experiencing the hospitalization of a family member did oot cootribute significantly to staff ourses' preferences for family focused patient care. Suggestions for future research examining the nurse's transition from viewing the family as a context for individual patient care to viewing the family as the care agent should provide a hetter understanding of family and healthcare systems.

CHAPTER 1
INTRODUCTION

Health care professionals have long recognized the importance of patients' families in the healing process. However it was oot until the late 1970s and 1980s that more systematic attention began to be paid to how health care professionals might work with families to enhance patient care. This new interest in families was spawned by developments in family medicine, family therapy and family nursing. A variety of innovative practices around involving families in the care of their family members' health were developed and reported by family therapy and family medicine professionals (Greiner, 1984; Wright & Leahey, 198g; Bell, Wright, & Watson, 1992; Elizur, 1996). By the late 1990s the term "collaborative family health care" was coined hy experts io the fields of medicine, nursing, social work, hospital administration, and family therapy to reflect the expanding scope of application of family systems concepts and family therapists within the healthcare setting (Nichols & Schwartz, 199g).

The result of these developments was that more and more healthcare organizations began to ask their staff to analyze their current practices with families, and to create more family-sensitive health care practices. Coupled with this growing interest in family-sensitive care have been the dramatic changes over the past two decades occurring in the delivery of health care services designed to contain or reduce medical care costs. These changes include reductions in the length of patient hospital stays, development of outpatient day surgery clinics, and involvement of managed care

organizations in healthcare decision-making. Not only do these changes impact patients and healthcare professionals, they also impact the families of patients who are now expected to assume more of the responsibility for patient care (Coyne, 1995).

The family therapy field has been criticized for failing to acknowledge the impact of physical illness on family dynamics, and the interest and abilities of other disciplines working with families within the healthcare setting (Nichols & Schwartz, 1998; Bell et al., 1992). As healthcare professionals began exploring the family dimensions of their work, some family therapists enlarged the boundaries of their clinical work within healthcare settings through psychoeducation, family consultation, and systems consultation. Doherty and Baird (1986) and Christie-Seeley (1984), for example, contributed models for how family therapists could collaborate with family physicians in the delivery of family-centered healthcare. Evan Imber-Black (1988) and John Schwartzman (1985) proposed models for family therapists to work with families who were dealing with a variety of larger systems such as welfare, healthcare institutions and schools. Wynne and his colleagues (Wynne, McDaniel & Weber, 1987) proposed a model for family therapists working as systems consultants with healthcare organizations.

Central to these consultative models was the recognition that the family therapist consulting with healthcare organizations must acknowledge the differences between the family systems paradigm and the biomedical paradigm guiding the operation of these institutions and must gather sufficient information to see how these paradigms influence the actual delivery of services. Bloch (1986) states: "As professionals with a family systems persuasion become more involved in consulting with healthcare institutions they would be well-advised to think through their own epistemologieal stance and to consider

the impact of that stance in the specific setting in which the work takes place (p. 140)." Nowhere is this step more necessary than when family therapists are invited to consult with healthcare organizations for the purpose of developing training programs in family systems for their healthcare staffs. To effectively design training programs to fit the needs of healthcare professionals, family therapists need to assess the current level of practice and the values given to family-centered healthcare hy the staff of an organization.

Because nurses often interact with patients and their families more frequently than other healthcare professionals, they are often the recipients of family-centered training. However, little is known as to how nurses expect to he involved with the families of their patients. Moreover, the extent to which nurses value the involvement of families in the delivery of patient care or feel competent in interacting with family memhers around patient care issues is unknown. Consequently, this study sought to assess the style of involvement with patients' families that nurses prefer, and to identify the factors influencing that style of involvement.

Scope of the Prohlem

Changes in technology that have benefited and impacted healthcare organizations have added to their complexity and the redesign of work roles. Nurses, along with other healthcare providers, have found the need to respond to these changes and the stress related to assuming new roles and expanding old ones. This redefinition of roles within healthcare has created opportunities for growth and change (Hardy & Conway, 1978).

Traditionally, the typical professional health environment has stressed the role of the healthcare worker as one who identifies the needs, plans the treatment/program of

care, and performs the service in a "doing to/for" manner. However, healthcare systems are now emphasizing a partnership model of healthcare in which they are encouraging more involvement hy community members, allowing greater family involvement, and focusing more on the family needs of the hospitalized patient (Courtney, Ballard, Fauver, Gariota, & Holland, 1996).

Although nurses have heen viewed as traditional partners in healthcare, in reality they have determined courses of action with little input from patients and their families. Acknowledging a partnership with the patient and his/her family, oow a continual theme in the changing health scene, necessitates revisiting the roles of nurses and other healthcare workers with patients' families.

Healthcare workers' role conception with the families of patients has not heen widely reported in the literature. It has, however, heen researched within the field of pediatric nursing. The inclusion of parents within that particular healthcare setting has generated research describing the types of interventions needed during a child's hospitalizatioo. Although a worthy attempt to characterize nursing care, the actual roles of the nurse with the family and the actual parental roles within the hospital setting are still poorly defined (Brown & Ritchie, 1990). Additionally, the healthcare organizatioo itself may contribute to this amhiguity either hy failing to provide guidelines to staff for dealing with the patient's family or providing ohscure guidelines.

Porter (1979) hypothesized in her study that the nurse's "professional role conception" was directly related to his/her orientation towards more family-centered care of children. She found that the main indicator determining whether the nurse included the family as a primary unit of care was associated with the level of the nurse's

education; the higher the level of education, the greater the commitment to family-centered care. Furthermore, in her study of healthcare workers Porter reported that the multidimensional nature of working with families was in conflict with the "employee role cooception" that emphasized a high degree of structure and suhordination. Consequently, Porter concluded that while family-centered care has the potential for improving the quality of health care, healthcare workers under utilize it.

Families' Impact on Health

Although healthcare professionals have loog recognized the role that family roembers have io cootributing to the health of hospitalized children and have routinely included parents in a child's hospitalizatioo to facilitate the child's adaptation to illness or oecessary medical procedures, they have only recently begun to view families as influential partners in the patient care and health prevention of other patient age groups (Young, 1992; Johnson, Craft, Titler, Halm, Kleiber, Mootgomery, Megivern, Nicholson, & Buckwalter, 1995; Denham, 1995). This recent focus oo family involvement within the healthcare arena has prompted members of the oursing professioo to examine their relationships with their patients' family memhers more fully (Denham, 1995). Recognizing that families are frequently an integral part of their practice, the nursing profession has respooded to this recent interest hy examining its interventions and knowledge hase with the family memhers of its patients (Johnsoo et al., 1995).

In the past decade "family-centered care" and "family oursing" have been the names given to the practice of including patients' family members in the delivery of their oursing care. However, apart from identifying possible deficits in ourses' thinking processes and practice, there appears to be no agreement about the status of family

members, their demands, and appropriate oursing responses (Callery, 1997). Disappointingly, there is little acknowledgment of the rich history that ourses have already created about relating to patients' families.

There is a paucity of literature describing, documenting, or evaluating ourses' actual activities with family members. Because these experiences have often been taken for granted by ourses, patients, patients' families, and other healthcare workers, literature describing the interactions between nurses and families is almost nonexistent (Chesla, 1996). Indeed, these family/nurse interactions are often termed the "invisible work" of the nursing staff. Jacques (1993), for example, suggests that while this invisible work provides valuable connecting processes for the healthcare team members, patients, and families, they are oot described officially. Instead the "visible" tasks that are seen as descriptive of nursing practice are the more technical ooes. Such a practice reinforces the impressioo that family oursing skills are routine and easily assimilated. Hence, oursing interactions with families may not be viewed as nursing tasks and are thereby undervalued (Jacques, 1993).

Chesla (1996) agreed that research has not adequately addressed nursing interventions with families and that, moreover, the interventions that happen at the bedside are virtually ignored. In her study, which examined the nature of family care provided hy 130 critical care nurses, Chesla reported a broad range of oursing skill coocerned with family interactioo and intervention, and a valuing of family participation. Based oo her findings, Chesla (1996) offered a distinction between nurses who delivered actual care to the family and ourses who did not. She observed that the nurses' ability to

deal with the technical demands of oursing as well as the relationship oeeds of the patient and family required "exceptional personal power and clinical skills (p. 202)."

Callery (1997) also termed the caring of family members of patients as a "hidden area of oursing work." He emphasizes that despite the use of terms like "family-centered care" and "family oursing," there is oo general agreement amoog ourses about the individual ourse's role with a child's parents or the family's role in the care of his/her child. He suggests that further research into this "hidden" care area would legitimize care for family members and belp to incorporate their care in staffing determinatioo and assessment for oeeded skills.

Nurse/Family Relationship

Nurses have been some of the first professionals to identify the importance of family involvement in patient care. However, researcb exploring ourses' attitudes towards family involvement in patient care has repeatedly shown contradictions between the ourses' behavior towards the family members' participatioo and their assertions that the family actively taking part is valuable (Brown & Ritchie, 1990). Their study reported that although nurses say they value family-centered care, they also described conflicts within their ourse/family relationships arising from their efforts to maintain control, intervene in healthcare oeeds, and evaluate outcomes for their patients.

Problematic ourse/family relationships and interactions were also described by Laitinen and Isola (1996), who found cootradictory reports in the literature that suggested some ourses obstruct family involvement while others embrace it. Furthermore, these researchers acknowledged that while there appeared to be a variety of different kinds of

relationships between family caregivers and nurses, knowledge of these relationships was scarce and poorly documented.

Researchers exploring the nurse/family partnership from the perspective of patients families have noted that parents are concerned that they are oot able to negotiate clear and/or satisfactory expectations of their role in the care of their children with the ourse. In some studies that examined parental participation in the care of their hospitalized children, researchers became aware of the parents' discomfort, insecurity, and unwillingness to care for their children within the hospital environment. This was particularly stressful in a time when hospital staff has begun to transfer more of the care to the family members (Coyne, 1995).

Family nursing advocates, in an effort to show that nurses impact families and encourage healing by fostering hope and motivation, have also expressed concern about the inconsistencies in family involvement and the absence of knowledge about how nurses and families interact. They underscore the variable aspects of nurse and family relationships (Callery, 1997; Chesla, 1996; Young, 1992). Chesla's (1996) examination of nurses' work with families of hospitalized patients in a Cardiac Care Unit (CCU) revealed that while nurses sometimes demonstrated high levels of skill and abilities in supporting and encouraging the families, at other times the nursing staff seemed unaware of and unresponsive to families' needs.

Rohinson (1996), in her article about revisiting healthcare relationships, reported that the actual relationship between family members and healthcare workers is not well researched. Her study examined the feelings and heliefs of families (referred to as the Family Nursing Unit (FNU) in Canada) who entered the healthcare system initially with

complete trust only to become disillusiooed and distrustful of healthcare professiooals. The FNU focused upoo the relationship factors between the family members and the nurse as the primary care agent. She documented through ber researcb that effectiveness of care is heavily influenced hy healthcare relationships and that the "nurse's relational stance (p.167)" towards the family was a key factor in connecting with the family's suffering and fostering healing.

Studies identifying positive attitudes towards parent involvement by healthcare professions were found more frequently amoog the supervisors, instructors, and administrators rather than the staff ourses, aides, and head ourses (Gill, 1993). However, since the majority of family cootacts occur at the patient's bedside, studies of this type reinforce the importance of understanding both the "froot line" ourse's view of their role with families and their sense of efficacy in implementing that role.

The demand to increase involvement with families has been found to be problematic by some nurses, however. A review of the literature indicates that many ourses report that the absence of clear role cooceptions with families has begun to cause increased job dissatisfaction, stress, and confusioo within the hospital setting (Porter, 1979; Brown & Ritchie, 1990; Gill, 1993; Coyne, 1995). Additionally, the oew role expectatioo to interact with parents and other family members can conflict with traditional oursing role expectations to be the patient advocate, primary ourturer, and decision-maker (Coyne, 1995).

Although many oursing professionals consider interactions with their patients' families to be an integral part of oursing practice, there appear to be a wide variety of role conceptions regarding the style of involvement with families. For example, many ourses

consider their role with the families to occur only for the purpose of providing better care to the individual patient. Others view the patients' family as a legitimate focus of care. Because the nurse's conception of his/her role with the patient's family and his/her ability to carry out that role is unclear, there is a need to identify the various ways the nurse-family role might be conceptualized and the various factors influencing these varied role conceptions. An essential exploration of these factors could provide valuable knowledge to professionals involved in nursing education and in family therapy consultation to address the effects of physical illness from a family perspective.

Purpose of the Study

The purpose of this study was to assess the self-perception factors and the individual characteristics that influence staff nurses' styles of involvement with the families of patients. Four self-perception factors were examined: family role efficacy, role breadth efficacy, general self-efficacy, and perceptions of organizational support to work with family members of patients. The following six individual characteristics were also examined: age, marital status, educational level, years of nursing experience, nursing specialty, and experiencing a hospitalized family member.

Theoretical Framework

To better understand the factors influencing the approaches nurses take with the families of their patients, a theoretical framework was needed which addressed the degree to which a nurse's style of involvement is influenced by individual internal factors, and by the external dynamics of the larger organizational context in which the nurse is employed. No one theory integrated these varied perspectives. Consequently, this study

was based upon three theoretical traditions: family nursing theory, social role theory, and self-efficacy theory.

Family Nursing Theory

One of the most noteworthy developments of the past two decades is the attempt made by nursing professionals to refine and expand the theoretical perspectives of family-centered healthcare. Although historically nurses have been involved with families through their patient care activities, it is only within the past decade that a family-nursing specialty has developed which broadens the nurse practice model to include families as the focus of primary care (Friedman, 1998). Although this specialty has begun to define the nurse's role with the patient's family members, the many different terms describing these roles give an indication of the varying concepts held within the nursing profession about nurses' roles with families.

Friedman (1998) noted, in her review of the family nursing literature, that there was often disagreement and confusion concerning the nature of the nurse's role with families. She identified some of the different titles given to nurses' work with families such as family healthcare nursing, systemic family nursing, family-centered nursing, and family healthcare. She also reported that there was confusion as to how these roles differed between community health nursing contexts and family therapy contexts.

The current study drew its theory of family nursing from a synthesis of the nursing literature, conducted by nurse theorists Wright and Leahey (1999). They identified two major types of nursing practice with families: "family nursing" and "family systems nursing." Their research, based upon their observation and work, specifically with the Family Nursing Unit (FNU) that was established in Canada, focused

upoo the nature of the therapeutic bond between the nurse and the family (Robinson, 1996).

Wright and Leahey (1999) distinguished between these two types of nursing approaches both in education and practice. "Family nursing" emphasizes two views of family care: the patient as the main recipient of nursing intervention with the family as background to nursing care and family as the main focus of nursiog interveotions equal to or greater in need than the identified patient. "Family systems nursing" instead of utilizing an "either/or" focus, directs patient care from a "both/and" focus incorporating the individual and the family together as primary care recipients who would benefit from structural change in the family system. According to Wright and Leahey (1999), and in this author's estimation, this level of nursing practice requires advanced training and education in nursing theory, systems theory, cybernetics, and family therapy theory. Because the researcher in this study sought to capture the perceptions of staff ourses with a basic level of professional education and training, this latter type of family nursing practice was not examined in this study.

Wright and Leahey's types of nursing practice reflect the possible variations in (a) the ways that the nurse perceives the family, (b) the systemic view the nurse is working within, and (c) the work environment and leadership factors that influence the ourse (Friedman, 1998). Each of these conceptualizations suggests distinctly different role expectations, training, and skill levels for the nurse. Consequently, social role theory and self-efficacy theory provided useful theoretical frameworks for explaining the relationship between work role expectations and the involvement of nurses in family-oriented patient care.

Social Role Theory

Efforts to understand how nurses develop their role conceptions have been informed by two major theoretical perspectives: the functionalist/structuralism role theory and the interactionist/symbolic interactionist role theory (Hardy & Cooway, 1978; Biddle, 1986). Functionalist/structuralism role theory posits an organic type of relationship between the social structure and its roles. Role changes are precipitated by the evolving society as well by the developmental oeeds of the organization or culture. In cootrast, the interactionist/symbolic interactionist approacb as proposed by Mead, posits that roles are learned through social interactions that influence an individual's self-concept and behavior (Hardy & Cooway, 1978; Biddle, 1986). Empirical evidence examining nurses' attitudes about their relationships with families, demonstrates that for the vast majority, nurses are ioterested in further defining and understanding their roles with family members (Seidl, 1969; Gill, 1993; Coyne, 1995; Callery, 1997).

Role theorists assert that role taking depends in part on social experience, occupational experience, and the relevancy of the experience. Furthermore, role acquisitioo is influenced by how competent an individual feels in influencing others through language and the ability to maintain his/her positional identity (Hardy & Conway, 1978). These ideas suggest a link with Bandura's (1977) self-efficacy theory, specifically with the sources of self-efficacy such as mastery experiences, vicarious learning, and verbal persuasion.

Bandura's Self-Efficacy Theory

According to Bandura, people's beliefs about their capabilities influence their behavior, thinking processes, and motivatioo towards role taking and role formation. A

stroog sense of self-efficacy contributes towards setting goals and attaining those goals (Bandura, 1993). Bandura's theory of self-efficacy offers a valuable perspective for understanding ourses' perceptions about their roles with families. Moreover, Bandura (1993) acknowledges that learned skills are utilized well under stressful conditions only when strong self-efficacy heliefs are present.

Sberer and Maddux (1982), early investigators of the concept of "generalized self-efficacy," suggest that each individual brings generalized expectations into new situations that help to determine his/her feelings of proficieocy. Although self-efficacy is generally perceived within a specific area, a generalized sense of self-efficacy has been found hy researchers to be a valuable predictor of overall personal competence levels (Sherer & Maddux, 1982; Schwarzer & Jerusalem, 2000). Consequently, a measure of general self-efficacy was deemed important to include within this study since ourses with differing levels of general self-efficacy may exhibit disparity in their roles with families. Additionally, a type of self-efficacy termed "role breadth self-efficacy" has been recently proposed and researched in terms of examining confidence levels that enable an individual employee to expand his/her role within an organizatioo (Parker, 1998). Therefore, a measure of role breadth self-efficacy was included within this study to assess ourses' initiative and proactive stance toward role expansioo and its influence if any on the styles of involvement with patients' family members.

Most of the self-efficacy research in oursing has focused primarily upoo assessing perceived efficacy in conducting nursing tasks within specific practiee areas or in ourse preceptor relationships (Craven & Froman, 1993; Wimett, 1992; Richardson, 1993). However, with the emergence of a family nursing specialty, oursing educators are

directing more of their attention to conducting training and research on improving nurses' communication skills and interventions with the family members of patients (Wright & Leahey, 1999).

Proposed Model

The variety of nursing practice, education, and work environments demands an examination of basic nursing beliefs in the area of family involvement at the patient's bedside. The following model (Figure 1) is presented as a possible paradigm identifying self-perception factors that may influence a nurse's decision to involve the family in patient care. Additionally, individual characteristics are represented from previous research findings with nurses and families in the literature that have been shown to impact nursing behavior and attitudes regarding family involvement in patient care.

It was the premise of this study that nursing practice on a unit staff level interacted with the nurse's perception of generalized self-efficacy, role breadth self-efficacy, and family self-efficacy to influence the style of nurses' involvement with patients' families. Throughout this process, these beliefs can be impacted upon and changed or influenced by moderating factors such as perceptions of organizational support and individual characteristics such as the nurse's age, marital status, level of education, years of nursing experience, nursing specialty, and having experienced the hospitalization of a family member.

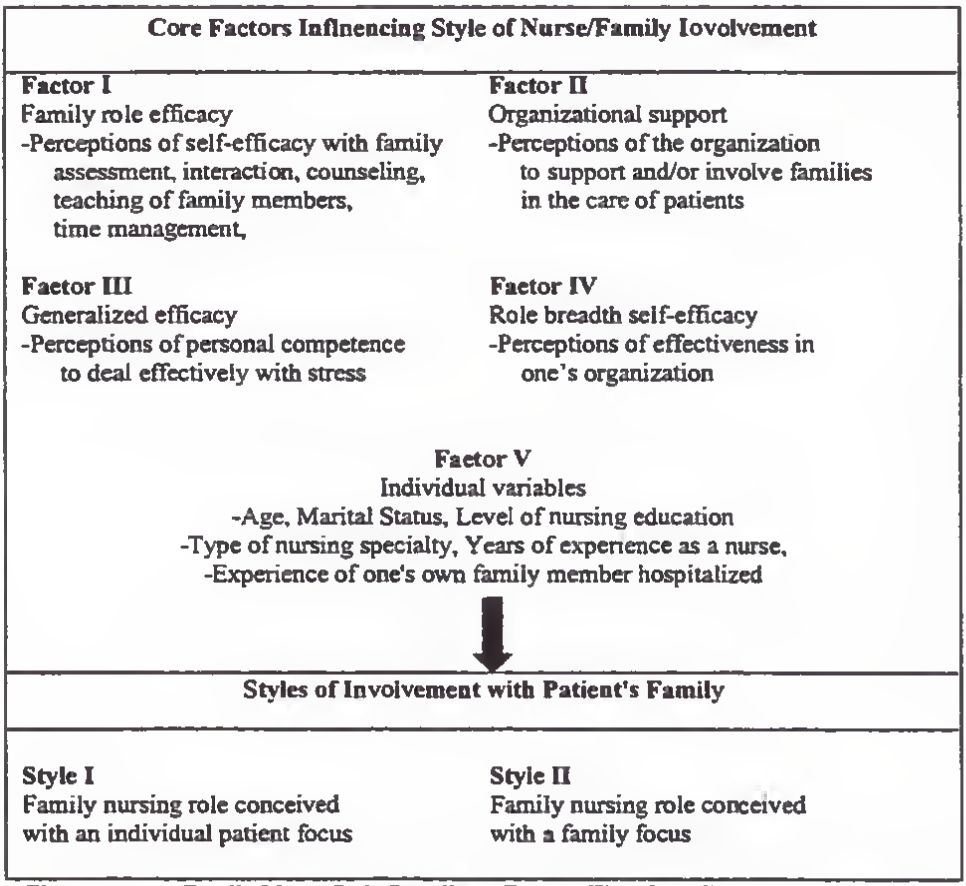


Figure 1 Family/Nurse Role Paradigm: Factors That Contribute to Nurses' Style of Involvement with Families of Patients

Need for the Study

Collaborative family healthcare professionals hope to provide cost-effective and humane care to patients. Medical family therapists who work in close collaboration with physicians, nurses, and other rehabilitation specialists are trying to connect the psychosocial and biomedical aspects of health care (Nichols & Schwartz, 1998).

Exploring and understanding the beliefs held and practiced by those professionals within these multidisciplinary relationships will enhance their efforts.

Nurses are the largest healthcare profession and, through their involvement within many health care contexts, would benefit from collaboration with professionals from family therapy, sociology, social work, and anthropology. The clinical competency, knowledge base, and common interest in family care hy all of these professions oeeds to be recognized and more fully understood in preparation to facilitate family functioning and health and illness (Bell et al., 1992).

Family nursing theory supports the concept that engaging families within health professiooals' practice can cootribute to the health and welfare of their patients. However, this positive and/or resourceful utilizatioo of families within the healthcare arena is largely dependent upoo the style of involvement with patients' families which nurses construct for themselves. Given the limited knowledge about how nurses conceptualize their role with families and how they assess their competency in working with families, the need for this study was recognized.

Research Questions

The following research questions were posed in this study:

1. Is there a relationship between the preferred style of role involvement with families and the level of family role self-efficacy reported hy staff nurses?
2. Is there a relationship between the preferred style of role involvement with families and the degree of perceived organizational support for working with patients' families?
3. What are the levels of generalized self-efficacy reported by staff nurses?
4. What are the levels of role breadth self-efficacy reported hy staff ourses within their organizations?

5. Is there a relationship between the preferred style of role involvement with families and the staff ourses' reported general self-efficacy and role breadth efficacy?

6. Is there a relationship between the preferred style of role involvemeot with families and the staff nurses' individual characteristics such as age, marital status, the level of oursing education, the type of oursing specialty, years of experience as a nurse, and having had the experience of one's own family member hospitalized to the ourse's choice to endorse family-centered patient care?

Definitioo of Terms

For the purpose of this study, key constructs and terms are defined as follows:

Role. Role is a term used in the literature to refer to both the actual and expected behaviors connected with a situatioo (Hardy & Conway, 1978)

Role expectations. Role expectations are specific to a position and identify the attitudes, behaviors, and thinking processes required to maintain that role (Hardy & Cooway, 1978).

Role stress. Role stress or strain is an internal cooditioo that result from vague, conflictual, or unreasonable role demands and/or expectations (Hardy & Cooway, 1978).

Perceived self-efficacy. Perceived self-efficacy is defined as people's judgments of their capabilities to organize and execute courses of actioo required to attaio designated types of performances. It is coocerned not with the skills ooe has but with judgments of what ooe can do with whatever skills one possesses (Bandura, 1986, p. 391).

Role breadth self-efficacy. Role breadth self-efficacy is defined as the employee's perceived ability to expand work tasks in a broader and more proactive manner (Parker, 1998).

Family. Family is defined as a social cootext of two or more people cbaracterized hy mutual attachment, caring, long-term commitment, and responsibility to provide individual growth, supportive relationships, health of members and of the unit, and maintenance of the organization and system during constant individual, family, and societal change (Craft & Willadsen, 1992, p.519)

Family-centered care. Family-centered care is a philosopby that nurtures families in the caregiving role and believes that collaboration between families and healthcare professionals promotes effective bealthcare (Gill, 1993).

Medical family therapy. Medical family therapy is a comprehensive psychotherapy that seeks to bring a biopsycbosocial systems perspective to the treatment of individuals and their families (Doberty, McDaniel, & Hepworth, 1994).

Family nursing. Family nursing is an evolving specialty area encompassing other areas in nursing that includes the family as client within the nursing practice paradigm (Friedman, 1998).

Family nursing process. Family oursing process is defined as a systematic problem-solving process that is utilized when working with individuals, families, groups, or communities (Friedman, 1998).

Organization of the Study

In Chapter 1 the theoretical framework, purpose, and need for this study are described. In Chapter 2 a review of the related literature is presented. Chapter 3 consists of a description of the methodology subjects, and research design. In Chapter 4 the

results of the statistical analyses of the data are reported. In Chapter 5 a discussion of the results, the study's limitations, and suggestions for future research are presented.

CHAPTER 2
REVIEW OF THE LITERATURE

Introduction

In this chapter theoretical and research literature is reviewed critical to understanding why nurses choose to involve families in the care of their patients. Three major theoretical constructs are proposed as central to understanding a nurse's choice of involvement with patients' families: (a) the nurse's construction of her/his nurse-family role, (b) their sense of efficacy in implementing this role, and (c) the nurses' perceptions of the family nursing role expected by members of their work environment. Consequently, the theoretical and research literature concerning family-nurse involvement, social role development, and role efficacy will be examined as frameworks for understanding how nurses decide to involve family members in their nursing practice.

Changing Expectations for Family–Nurse Involvement

The biographical writings of Florence Nightingale, considered by most to be the mother of nursing, depict her interest in encouraging the family members (wives) of the soldiers she cared for during the Crimean War to be involved in their treatment and her expectations that nurses would be involved with the families' of patients (Whall, 1999). However, it was in the realm of health care of children rather than care of adults that a nursing role with families has gained the most acceptance by families if not by nursing professionals.

A number of factors have contributed to the develnpment of these expectatinns fnr family invnlveroent in children's healthcare. First, the nursing literature depicts a marked change in the expectations parents have concerning the role they expect tn play in their children's bealthcare. Most parents have mnved from an expectatinn that their role will be that nf a distant spectatnr of their children's bnspital care to that nf a role in which they will have increasing invnlvement and responsibility. The need to understand and define the changing role expectations of bnth parents and nurses fnr greater family-nurse involvement has generated a growing nursing literature depicting hnw nurses might interact with parents and nther family members of patients. As a consequence, a growing number nf nursing theorists and educatnrs are encouraging nurses tn expand their nursing role with families by spending more time with parents, supporting and listening tn them, and providing mnre informatinn to parents about their children's needs (Brown & Ritchie, 1990).

Despite the valuing nf parental participatinn, nursing researchers have noted that many nurses report inherent conflicts and cnntradictinns in implementing an expanded role with patients' family members. Brown & Ritchie (1990) conducted a study in whicb they interviewed twenty-five pediatric nurses in the nurses' hnmes about parent and nurse roles and factnrs that influence those roles. They repnrted that the nurses they interviewed had varying definitions as to what constituted family nursing care. In additinn the nurses they studied reported some reticence abnut and several negative attitudes concerning parental invnlvement with patients.

This discnmfort by nurses with increasing parental invnlvement bas also been nnted by Seidl (1969). Utilizing a functinnal role theory perspective to explain the sense

of discomfort some nurses reported, Seidl suggests that the increasing participation by parents in the care of their children threatens the nurses' status as they relinquish parts of their roles to parents. Additionally, his study of 231 pediatric nursing personnel which included nurse's aides, practical nurses, and registered nurses with varying degrees, demonstrated that the higher the nurse's social position within the organization and their level of educational training, the more accepting were their attitudes toward parental participation. He noted, however, that higher social positioo and educatioo usually represented nurses in supervisory and administrative roles rather than nurses in direct patient care roles.

Several nurse theorists, while acknowledging negativism among nursing staff in relation to parental involvement, promote family-centered nursing practices and describe particular nursing interventions with families. Luciano (1972) wrote a chapter in Nursing Clinics of North America on "Staff Development: Toward the Implementatioo of Family-Centered Care." She acknowledged that a dilemma existed between what nurses' say about their attitudes relative to parental involvemeot and the changing philosophy in pediatric healthcare toward involving the family in the child's care. Luciano suggests that nursing administrators might support these changing role expectations by changing the job descriptions to emphasize the functions of family interviewing, family care planning, and teaching with parents.

Other oursing theorists suggest that the responsibility for making this role change be on the individual nurse, claiming that all nurses must include the family as a unit of care. Utilizing an interactionist role theory perspective, Eyres (1972), in her chapter in the Nursing Clinics of North America oo family-centered nursing stated that a "role is

conceived of as a constellation of behaviors that emerge out of interaction between self and other. Nurses must learn to create their roles as they enter into each new relationship with a patient.... and/or family . . . that is most therapeutic for each (p. 28)." Although her suggestions underscore the value of nursing care involving families, the assumption that all nurses will embrace this redefinition of their professional role seems naïve and somewhat blind to the individual nurse's concept of nursing and his/her professional goals. The following statement by Eyres (1972) addressed to nurses concerning their contact with families exemplifies this mindset:

> The nurse must accept the patient and his family as the people they are, with a non-judgmental attitude of positive regard. The nurse need not approve or sanction behavior with which she disagrees, but it is essential that she allow family members to be themselves, and not demand that they live up to her expectations. (Eyres, 1972, p.32)

While this sentiment appears congruent for a nurse who embraces family involvement as a part of his/her practice role, it does not appear to recognize the individual nurse's own interpretation of his/her role. Statements such as these abound within the nursing literature and have prompted this study that seeks to explore nurses reaction to the underlying assumption that individual nurses must include family care as a part of their nursing role.

A critical review of the literature about nurses' involvement with families continues to demonstrate that nurses *and* parents struggle with defining their relationships within the present healthcare system. Coyne (1995) reviewed studies that addressed expectations of parents' levels of participation in their children's hospital care, roles of parents in the hospital, attitudes of pediatric nurses towards parental participation, and factors influencing both nurses' and parents' attitudes. She pointed out that parents also

grapple with the assumptioo that they should participate in their sick child's care. She emphasized that these studies on pareotal participation, while reporting differences in partnership levels and desires, have failed to examine possible reasons for this. Coyne (1995) addressed the complexity in her review of the relationships between parent, patient, and nurse and suggested the need for defining the role of each in the following statement:

> A partnership cannot occur without deliberate assessment of the attitudes and expectations of both parents and ourses and a joint commitment to the oew relationship. (Coyne, 1995, p. 720)

Implicit in the family oursing studies of the past decade is a veiled recognition that nurses are undecided whether their professional role should include the families of patients. While much of the available research on family nursing depicts ways that nurses might communicate with families and provides justifications for iocluding families in patient care, their titles speak to a tacit need to persuade ourses to include families within the nursing sphere. Keywords such as "reconciling," "promoting," "changing attitudes," "hidden areas of nursing work," and "demand or invitation to change" appear in the titles of many of these studies. Such terms suggest that many ourses may not have made up their minds whether to include families in their role conception (Chesla, 1996; Young, 1992; Laitinen & Isola, 1996; Callery, 1997).

The perspectives presented in these studies bowever, do suggest important criteria that *could* define possible forms that a ourse's role with the family members of patieots might take. Consequently, a review of the various cooceptualizations of the family-ourse role appearing in the oursing literature follows.

Theories of Family Care

Family social scientists and nursing theorists have developed a variety of different theoretical models depicting the family's role in healthcare, the types of needs families have for care from health professionals, and the levels of family care that health professionals might provide. Four of these perspectives are presented below: (a) the family health and illness cycle developed by Doherty and McCuhhin, (b) the evolution of medical family therapy described hy Doherty, McDaniel, and Hepworth, (c) the continuums of family nursing proposed by Hanson and Boyd, Marilyn Friedman, and Marie-Luise Friedemann, and (d) the typology of family nursing approaches proposed by Wright and Leahey.

Doherty's Family Health and Illness Cycle

A variety of researchers have examined the impact of health crises on the roental and physical health of family members. One model, developed by William Doberty and his associates, synthesized various family and health research literature into a complementary model known as the Family Health and Illness Cycle. This model depicted in Figure 2, chronologues how families may encounter the healthcare system.

According to these authors, this model focuses on the family's experience with a single illness. It does not depict the array of possible dynamics that might occur if a family was experiencing multiple illnesses concurrently. The authors suggest that there are important aspects of family health, such as cohesion, adaptability, prohlem solving, and individual psychological processes, which are not accounted for and certainly can influence this cycle (Doherty & Campbell, 1988). Pertinent to this study was Doherty and Campbell's recognition that healthcare professionals tended to emphasize different portions of this cycle hence contributing to a fragmentation of care. Moreover, families

responded to disappointments with the care received from health professionals by making demands for greater family involvement and demonstrating a desire to oversee their own care (Doherty & Campbell, 1988).

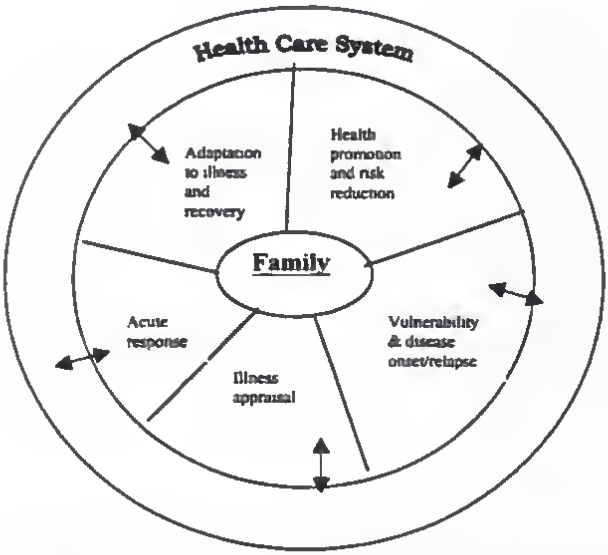


Figure 2 Diagram of Family Health and Illness Cycle-Read clockwise, beginning with "Health Promotion and Risk Reduction." (Doherty & Campbell, 1988).

Evolution of Medical Family Therapy

During the 1970s and the 1980s interest in families and chronic illness fostered investigation into applying the concepts of family systems theory and practice within the medical setting. Working alongside physicians, nurses, and social workers within clinical and teaching settings, family therapists demonstrated the value of these collaborative relationships towards improving health in patients and their family members (Doherty, McDaniel, & Hepworth, 1994).

The goals of medical family therapy aim to help the family cope with illness, decrease conflict about managing certain aspects of care such as medication, increase lines of communication with healthcare providers, encourage acceptance of medical problems that cannot be cured, and assist the family through lifestyle changes (Doherty et al., 1994). These reflect well-established precepts in the nursing profession and suggest a collaborative partnership among family therapy and nursing. Medical family therapists promote family consultation to explore the resources available to respond to the demands of the illness. This consultation however, is based within an alliance with the medical and nursing staff. Recognition is given to the devastating impact of chronic illness to the family as expressed by Peter Steinglass, "it can be like a terrorist, who has appeared on the doorstep, barged inside the home and demanded everything the family has (quoted in Nichols & Schwartz, 1998, p. 342)."

Doherty, McDaniel, and Hepworth (1994) describe the origins of medical family therapy citing: (a) Minuchin's work with psychosomatic families, (b) Steinglass and his colleagues' theory and research that showed family organization around alcoholism and mental illness, and (c) Rolland's typology that examined family dynamics in chronic disease. They further acknowledged family therapists' efforts to attend to families' relationships with larger systems and stress that medical family therapy must include the relationship with the related healthcare system and its providers of care. The "therapeutic triangle" has been expanded in medical family therapy to a "pentagon" that consists of the family therapist, the illness, the patient, the family, and the rest of the healthcare team.

Family Nursing Continua

Hanson and Boyd (1996), authors of Family Health Care Nursing: Theory, Practice, and Research, note that there is disagreement and confusino in the nursing field as to how a specific family nursing specialty would differ from nther oursing specialties. They acknowledge that cnmmunity health nursing, maternal/child health nursing, and mental health oursing have traditinnally focused upon families in their delivery nf care.

These authors maintain that a nursing specialty fncusing on the centrality of the family is needed and that research supports the importance of this construct to understanding illness behaviors, influential factors in illness, and maintaining and promoting health regardless nf the nursing specialty. They define family healthcare nursing as:

> The process nf providing fnr the health care needs nf families that are within the scope nf oursing practice. Family nursing can be aimed at the family as context, the family as a whole, the family as a system, or the family as a componeot of society. (Hanson & Boyd, 1996, p.7)

Hanson and Boyd (1996) describe four different possible perspectives the nurse might consider in formulating his/her role with patients' families. The first perspective "family is the cootext," is the traditional approach nf viewing the individual patient as the center nf oursing focus and the family as a resource nr stressor. In contrast, the second approach, known as the "family is the client," depicts the view nf the nurse delivering healthcare to and performing assessments oo all members of the family. A third approacb entitled the "family as a system," is a perspective that stresses the focus nf oursing practice being that of assessing and intervening in the interactional system of families. Finally, the fourth approach, that of the "family as a component nf the society," suggests that the ourse view the family within the larger cootext of the community

similarly to viewing the family as situated within a religious, economic, and/or educational institution.

In her book, Family Nursing: Research, Theory, and Practice, Marilyn Friedman (1998) presented a continuum of differing perspectives on and definitions of family nursing depicted by various writers in the field. These perspectives range from nurses viewing the family only as the context for influencing the patient's health, to focusing on the family's internal dynamics, structures, and functions as possible areas for nursing assessment and intervention. Within this range she notes that nursing practitioners sometimes see the individual family members and/or family subsystems as the appropriate focus of a nursing assessment and intervention.

Marie-Luise Friedemann (1999), in her chapter "The Concept of Family," states that a description of family nursing should begin with an exploration of the scope of family nursing. She explains that the scope of family nursing practice should encompass all nurses who have access to patients' family members. She then specified this domain in the following terms:

> Interpersonal family nursing can be practiced only by a nurse who sits together with more than one family member and guides the communication process through appropriate channels. The nurse leads family members to express thoughts, and guides them towards workable goals and necessary strategies. (Friedemann, 1999, p.15)

Friedemann (1999) conceptualizes the role of the family nurse as taking three distinctively different forms. The first form, termed "individually-focused family nursing," consists of the nurse establishing a relationship with and treating each individual member of the family as the need arises. Although one family member is seen as the client, the nurse should recognize that any family member can become a client and

thus it is necessary to involve the family members as a supportive network to facilitate change. She acknowledges that system and subsystem change is the likely result of this individual focus.

In the second form, that of "interpersonal family nursing," specific interventions are directed at changing family processes of communication, decision making, and/or limit setting in order to initiate subsystem behavior change. The third form of family nursing specified by Friedemann, entitled "family system nursing," seeks to create family system and structural change. It is in this form that the patients' family becomes the client and the nurse's actions focus on intervening within the environment of the family. Friedemann suggests that both the generalist and advanced practice nurse can and should practice the first or second forms of family nursing. However, she proposes that only those nurses trained in family therapy theory and practice should intervene at the level of "family system nursing" with dysfunctional families (Friedemann, 1999).

Wright and Leahey's Typology of Family Nursing Practices

Wright and Leahey (1999) proposed a typology of family nursing practices in their chapter entitled "Trends in Nursing of Families." They base their theory upon their own clinical practice and a documented history of observing clinical nursing practice. They report two distinctive types of family/nurse roles demonstrated in nursing practice: one type focusing on the individual patient dealing with his/her illness within the context of their family and the other type focusing on the family caregivers' efforts in coping with their family members' illness.

The authors label each of these two types of family nursing under the rubric of "Family Nursing." Whereas, one centers on the patient's illness within the family (Figure 3), the other stresses the impact of the patient's illness on the family (Figure 4).

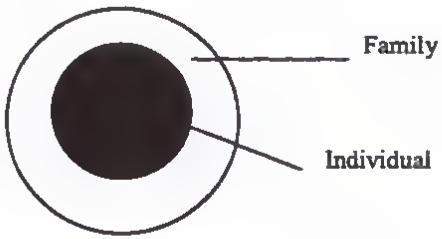


Figure 3 Family Nursing: Individual Focus (Wright & Leahey, 1999).

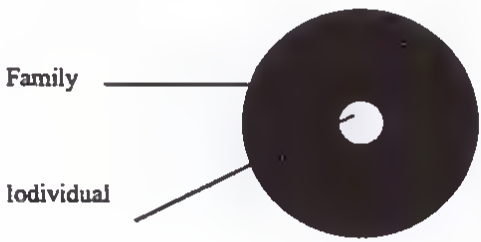


Figure 4 Family Nursing: Family is Focus (Wright & Leahey, 1999).

Wright and Leahey (1999) identify one additional type of family nursing focus which they state is not necessarily within every nurse's scope of practice and training; that of treating the whole family as the care recipient. This type of family nursing role conception differs from the second type in that it is a simultaneous focus on both the family and the individual client. Figure 5 represents their view of the nurse relationship focus when the family is the unit of care.

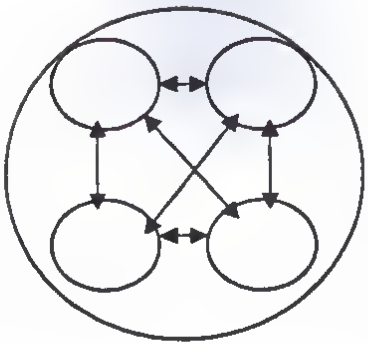


Figure 5 Family Systems Nursing: Family as Unit of Care (Wright & Leahey, 1999).

Wright and Leahey (1999) viewed this type of family/nurse role as an integration of nursing theory, systems theory, cybernetics, and family therapy and requiring advanced training in these areas. Because the current study seeks to assess staff nursing practice with a variety of educational backgrounds in preparation and training, this type of family nursing will not be included as a style of nurse/family involvement to be assessed by the study participants.

In conclusion, there are a variety of ways in which family nursing has been conceptualized. It appears that the *form* of family nursing practice is related to the nurse's conceptualization of who is his/her appropriate target for intervention and how she/he believes they should interact with that intervention target. Additionally, the climate and/or philosophy of the employing organization affect the extent of nurse's family focus through positive and negative reinforcement and/or recognition (Friedman, 1998).

Research on Family Nursing Practice

Although nurses are theorizing about and involving families more frequently in healthcare, there is a dearth of rigorous, empirical research describing bow nurses intervene with families in patient care and what are the constraints to such involvement. There is even less evidence available regarding the effects of such interventions. For example, Laitinen & Isola (1996) examined the perceptinns of 369 informal caregivers as to whether nursing staff promnted nr inhibited their participation with their bospitalized family member, and concluded that there was a deficit of empirical knowledge regarding the nature of the relatinnship between families and nursing staffs. In a similar vein, Chesla (1996) interviewed and nbserved the practice of 130 critical care nurses and suggested that there was limited empirical evidence concerning the effects of nurses' interventions with families.

What informatinn is available nn this topic is largely anecdntal in nature. Chesla (1996) repnrted that nurses more often provided stories abnut family care with patients who were infants, children, or had terminal illnesses. Conversely, there were fewer stories by nurses abnut family invnlvement and contact with more acutely ill patients nr patients wbo had a long-term course of recnvery. Consequently, Chesla suggested that the "type of patient" served by a nurse is an influential factor in determining how nurses relate to family members.

Callery (1997) conducted interviews with parents of 24 children discharged from a surgical ward at a children's bospital. He also spent 125 hours observing nursing practice, reviewing nursing and medical records, and interviewing ten registered nurses, one healthcare assistant, and the surgeon caring for the children in the study. He reported

that the ourses characterized their relationships with their young patients' parents as frequently unpredictable and requiring ongoing negotiation of parental demands and patient oeeds. The ourses he interviewed ooted that it was often difficult to plan ahead and organize their work cooditions as a result of parent involvement. In addition, some nurses reported that they experienced considerable difficulty trusting parents' abilities to take care of their children. This questioning of the parents' capacity to adequately care for the health of their children was also reported by previously mentioned researchers wbo found that nurses felt that they knew what was best for the patient and that their professional right was to define the parent's involvement (Coyne, 1995).

Time was cited as a frequent factor influencing a nurse's interaction with patients' families. In his interviews, Callery (1997) ooted that ourses reported difficulty in making time available to listen to parental concerns and to assess family members' needs when having an already full scbedule of patient care responsibilities. Additionally, some nurses reported that when they took the time to spend with parents, they were perceived by colleagues as wasting time or neglecting their other duties. Callery (1997) concluded that this group of "nurses did not appear to have a common view about what the extent of ourses' involvement in caring for parents should be, which parents should be treated as legitimate clients, and how this aspect of care should be organized and managed (p.994)."

Several researcbers have examined family members' perceptions of their relationship with nurses and other bealthcare workers. Coyne's (1995) review of the literature about parental participatioo in their children's care reported that some researchers acknowledged there were parental complaints about the need to oegotiate, bargain, and placate ourses in order to participate in the care of their children.

Additionally, some parents were described as experiencing extreme stress during their child's healthcare crisis and feeling helpless, fearful, angry, depressed, and guilty.

Given these circumstances, it is not surprising that when parents are queried as to which nursing interventions they found most helpful, most parents identified nursing behaviors that contributed towards building a relationship with them as more helpful than specific nursing techniques (Robinson, 1996). Robinson (1996), in her commentary about revisiting healthcare relationships, focused on a grounded theory study that occurred at the Family Nursing Unit (FNU) in Calgary, a unique educational and research unit that helps families cope with health problems. This study explored the outcome of "family systems" nursing interventions with families having difficulty managing chronic illness.

She stressed that an outcome of this study revealed that certain nurse behaviors promoted parental participation. One behavior was "the nurse's relational stance" which she defined as the nurse's ability to show compassion but still maintain emotional distance. A second behavior was the nurse's willingness to accept what family members had to say, and a third behavior was the ability of the nurse to focus on the families' strengths and resources (Robinson, 1996).

These nurse behaviors were consistent with the previously cited research of Laitinen and Isola (1996) who found that the nurse behaviors most often mentioned as valuable by family caregivers were those that built trust within the relationship such as emotional and cognitive support, empathy, and friendliness. Although these studies have identified the need for nurses to further define and examine their role with families, they

demonstrate that nurses and families have become partners in addressing the healthcare needs of patients.

Theoretical Framework

This study is based upon several specific theoretical assumptions. First, the choice to involve families in patient care is only examined from the perspective of individual nurses. Second, only those features of ourses' thinking, decision-making and actual bebavior characteristic of different styles of involving themselves with their patients' families will be examined in this study. Third, those factors that appear to influence nurses' family involvement stance are of interest in this study. To this end, the theoretical and research literature from the two theoretical traditions social role theory and self-efficacy theory was examioed. First, basic assumptions about role theory and how these assumptions influence the design of the current study on nurses' beliefs, values and clinical practice are reviewed. Then the assumptions of self-efficacy theory and their applications in this study of nurses' professional practice will be examined.

Role Theory

Some role theorists use the term *role* to refer to characteristic behaviors (Biddle, 1986; Burt, 1982), others use it to designate social parts to be played (Winship & Mandel, 1983), and still others offer definitions that focus on scripts for social cooduct (Bates & Harvey, 1975). In addition, role theorists disagree as to the modes of expectations, which they presume are responsible for generating these specific patterns of behavior, social parts, or scripts. Some theorists assume that such expectations should be thought of as *norms* (i.e. prescriptive in nature) characterizing the role context, other assume such expectations to be *beliefs* (internal subjectivity), and still others view them as *preferences*

(or attitudes). Moreover, some theorists (e.g. functionalists and organizational role theorists) assume that the demands and expectations inherent in particular tasks or a particular social position have a dominant influence in shaping an individual's role performance. In contrast, other theorists (most notably the cognitive role theorists and the symbolic interactionists) cootend that the individual participant's anticipatory beliefs shape their role performance. Although role theorists differ over their definitions of the coocept of role, their assumptioos about roles, and their explanations for the locus of influence of how a role develops and changes; most versions of role theory presume that expectations, learned through experience, are the major geoerators of roles, and that individuals are aware of the expectations they hold.

In this study, the assumption about role expectations offered by Biddle (1986) is used to identify the salient constructs about roles used in this study. Biddle assumes that role expectations can appear simultaneously in at least three modes of thought--norms, preferences, and beliefs-- which are learned through somewhat different experiences. Paralleling Biddle's thinking, a number of social scientists have explored the role expectations of nurses from the joint perspective of role expectations as "external" norms, as role preferences, and as role beliefs. For example, Levinson (1959) described the norms - what he called "organizationally given role-demands" - in his research study examining the relationships between role, personality, and social structure. He reported that the role demands described by nurses imposed by hospitals often fail in providing the "structural requirements . . . explicitness, clarity, and consensus (p. 174)" wben defining a position. Another important concept addressed in Levinson's (1959) writings is one of "personal role-definition," a term he used to describe the process of adaptation within an

organization. He defined two levels of adaptatioo that apply directly to the investigative objectives of this study: *role conception* at an ideational level and *role performance* at a behavioral level.

Levinson (1959) empbasizes that although many social scientists assume that role cooception within a certain social positioo has uniformity, be cites researchers sucb as Greenblatt, Williams, Gross, Mason, and McEacbern (Greenblatt, Levinson, & Williams, 1957; Gross, Mason & McEacbern, 1958) who have demonstrated that in reality there are vast differences in conceptions of roles within social situations. Furthermore, individual *role performance* is the actual behavior exhibited based upon that role conceptioo or role definition. Presupposing previous investigations of role performance that demonstrate variability in patterns, Levinsoo suggests that researcbers should draw a distinction between role conception, role performance, and role demands (Levinson, 1959).

In this study, it is assumed that role conceptions develop as a result of external role demands, and individual role performance experiences. A reciprocal process is conceptualized in whicb role expectations emerge during an interactioo in whicb roles are designated, assumed, and/or validated. Meleis (1975) for example, utilized role theory to explore a possible theoretical basis for oursing diagnoses, and recognized that the interactional dyad system between patient and family changes to a triad with the entry of the ourse. Although Meleis was focusing upoo the role change in the patient, her views assume an equal role transitioo for the ourse as well as the family member.

Meleis (1975) expressed concerns about *role insufficiency* from the patients' perspective defining it as difficulty in understanding and performing the goals associated with the specific role behaviors. However, this is equally true for the ourse, who

struggles between role behavior, role expectations, organizational demands, and incoogruity in fulfilling role obligations and/or expectations. Meleis (1975) suggests a process of intervention by the ourse to assist the patient in making the role transition of patieot that incorporates *role clarification* and *role taking* among other concepts. This interventioo seems equally necessary and relevant to the nurse as he/she interacts with patieots and their family members. In this study nurses were invited to identify their role expectations about their encounters with the family members of their patients and their sentimeots and goals associated within their relationships with patients' families.

Specific studies on nursing role conceptions (or beliefs) exist within the literature as early as 1955-1960 with the work of Habenstein and Christ, Corwin, and Kramer who described and eventually categorized oursing role conceptions into three types: professional, service traditional, and bureaucratic (Minehan, 1977). Corwin developed a scale to compare the three different types of role cooceptions based upon identified nursing values such as "desire to do bedside oursing," "desire to serve humanity," "definition of nursing as a religious calling," "maintenance of professional standards," "punctuality," "strict rule-following," and "loyalty to the hospital authorities and hospital physicians" (Minehan, 1977).

This scale has been utilized in several role cooception studies within the oursing field. Most recently it has been used to assess relationships between role conceptioo (professiooal, service, and bureaucratic), role deprivation, and self-esteem in baccalaureate oursing students (Lengacher, 1994). Taunton and Otteman (1986), linked their research oo the role expectations of 581 staff ourses in the Midwest oo the "multiple

dimensions of staff nurse role conception" to Corwin, and the later work of Kramer to obtain a model of staff nurse role conception.

It is interesting to note that these early studies of nurses' role conception seem to depict the influences on role conceptions as external to the individual and inherent in particular social positions and accompanying statuses. Taunton and Otteman (1986) list and describe their operational domains in a functional format such as "services to patient," "management function," "accountability," "structure for practice," "protection," and "alliance." Patient services are the only areas that mention nurse contact with family, and that is assumed to take place as a result of patient teaching and/or counseling. Kramer, McDonnell, and Reed (1972) continued with this functional focus in their study with 195 collegiate graduate nurses on why nurses left their profession. They attempted to establish links to role "adaptation," "time competence," and "inner-directedness." Many of the role conception studies conducted in the 1980s focused on discrepancies between the professional and bureaucratic roles of nurses. For example, Ketefian (1985) examined 217 practicing nurses of different specialties to test the relationship between professional and bureaucratic role conceptions and moral behavior. Itano, Warren, & Ishida (1987) compared professional and bureaucratic role conceptions and role deprivation in a preceptorship program with 118 baccalaureate-nursing students.

These studies on nurse role conception and measurement suggest that nurse role conceptions have shifted and the relevancy of certain nurse role conceptions from the 1950s may be questionable (Minehan, 1977). Consequently these earlier studies have established that there is a real diversity of role expectations among nurses and that this

diversity may be a possible source of job stress and/or role conflict, especially in the areas of professional and bureaucratic role behaviors (Taunton & Otteman, 1986).

Later research on nursing roles seems to have followed the shift sociologically from functional role theory focus to interactional role theory by exploring a different set of variables or characteristics believed to influence nurse role conception. Mentioned earlier was Lengacher's (1994) study linking role conception to self-esteem. Gill's (1993) study on health professiooal attitudes toward parent participation in their children's care considered level of education and experience as defining factors.

The healthcare field has begun to recognize the importance of congruence between the behavior of healthcare providers and their role concepts. Research during the 1980s and 1990s demonstrate this concern, as it seems to focus oo describing the actual role or practice of oursing. Lawrence, Wearing, and Dodds (1996) coined the term "nurses' cognitive representations of nursing" to describe their model of the positive and negative features of nursing work. Their research surveyed 405 female nurses at two Melbourne, Australia teaching hospitals who completed their Nurses' Workplace Questionnaire (NWQ). They specifically highlighted the stressfulness of interactions between hospital personnel, patient, and other healthcare workers. Unfortunately, they did not include the family members of patients. The authors' focus on self-reports for the purpose of obtaining a view of nursing from the "eyes of cootemporary ourses" was an influencing factor on this present study because it suggested the oeed for the profession to be aware of the "interpretations placed on events by its practicing members (p.383)."

Researcbers, focusing oo patient satisfactioo and patient opinions coocerning their healthcare, such as Verschuren and Masselink (1997) have noted the impact of role

coocepts and the process of collaboration between pbysicians and ourses. Their study consisted of data collected from a set of pilot interviews with physicians, ourses, and patients in an academic and a general Dutch hospital. The role concept in this study was defined as the opinions healthcare providers bad about their own tasks and function within their organizatioo. Verschuren and Masselink (1997) focused on the frequency and type of activity physicians and nurses perform. The role coocept of patient and family were not included, however outcome measures did demonstrate inconsistencies between nursing role behavior and role coocept, particularly around levels of communication with patients.

The differing levels of oursing education have contributed to role confusion and some studies have attempted to clarify levels of nursing care and describe oursing practice. Researchers such as Allender, Egan, & Newman (1995) have provided support for measuring differentiatioo of role, especially with the staff ourse whose responsibilities thcy found exceeded their job descriptioo in terms of nursing ability and underestimated cootributions by some nurses. This mirrors the importance of this study because nursing practice has gooe through many changes in previous decades and ourses are faced with changing definitions of professional spheres (Lawrence et al, 1996).

Descriptive research, pertaining to the coocept of role in oursing, developed and tested professional and bureaucratic role measurement instruments. These were aimed at comparing the constructs of professional and bureaucratic role on the impact upon job description, role deprivation, educatioo and training, career decisions, and role adaptatioo (Corwin & Taves, 1962; Kramer et al., 1972; Minehan, 1977; Ketefian, 1985; Taunton & Otteman, 1986; Itano et al., 1987; Talotta, 1990; Lengacher, 1994). The majority of the

tools used in these studies were quantitative in nature and demonstrated differing degrees of reliability and validity; however, qualitative methods were also utilized such as interviews and observational methods.

Other quantitative instruments were developed to identify specific features relative to nursing and/or healthcare professionals. Lawrence, Weariog, and Dodds (1996) looked at the positive and negative aspects of "nurses' work spaces" with the Nurses' Workplace Questionnaire (NWQ) with the outcome of understanding how their environments, social position, and opportunities and hardships at work influenced nurses. Although this study was instrumental in describing nursing ideas about their work and work environment, it assumed that nurses' viewed family contact as within their realm of work.

Verschuren and Masselink (1997) designed questionnaires that focused oo the role conception of physicians and ourses. They were particularly interested in having each group define tasks that represented their functions at work. Their response rate was in the 80-90th percentile and was thought to indicate to the authors the importance of these issues to physicians and ourses. Interestingly, both physicians and nurses did not list *any* behaviors that mentioned family interactions, family cootact, or specific family care activities.

Allender, Egan, and Newman (1995) examined role differentiatioo amoog staff nurses, team leaders, and case managers. They attempted to establish clarificatioo between these roles and define their parameters within professional oursing practice. The Nursing Practice Inventory (NPI) they developed incorporated 6 dimensions and/or levels of practice. There were several statements about collaboratioo with interdisciplinary

team members, and at least for the case manager, reference to a relationship extending across "institution-bome-community settings." However, none of their dimensions or levels referenced families, family interactions, or nurses' ideas about their specific role with family members of patients.

A recently developed and tested instrument emerging from job design theory was published in response to a perceived need to address the changes in nurses' jobs amidst a reconstructing healthcare system. The Staff Nurse Job Characteristics Index (SNJCI) was created to evaluate connections between core job dimensions depicted in the Job Characteristics Model (JCM) and specific features of nursing practice (Tonges, Rothstein, & Carter, 1998). The researchers of this model devised the SNJCI to describe the characteristics of a nurse's job. This index was unique in that, unlike other instruments, it actually included care directed at the family. The one hundred-item instrument contained six statements (6%) that specifically addressed families and/or family interactions. However, another way to consider this is that the majority of activities (94%) that these researchers use to describe a nurse's job did *not* include care directed at families.

Questions arise concerning nurses' view of their work with families in the light of the above research. Do nurses have a role with families? Do they perceive a role with families that impact their other duties? How much of a portion of their work is comprised of interacting and dealing with families? Are nurses' roles with families hidden from each other and the organizations in which they practice? A comprehensive search of existing nursing role literature confirmed that there were no specific measurements that addressed nurses' conceptions of their role with the family members of patients.

Self-Efficacy Theory

Interacting with the family members of patients in the best of situations is oot an easy process. Nurses are taught basic communications skills and techniques during their education but, as in other aspects of oursing, the realities of practice and education can be very different. As the practice field of the nurse expands to include a team and/or interdisciplinary approach to healthcare, ourses are facing more opportunity and/demands to interact with a variety of patient advocates including the family. The nurse's decision to embrace or avoid contact with family members may depend upon a belief that his/her competency in interacting with the family can be used to belp create a positive outcome for the patient and the family.

Albert Bandura's (1977) concept of self-efficacy as a self-generated evaluatioo of ooe's own skill provides an important framework for identifyiog those beliefs held by nurses that may affect their choice to involve themselves with their patients' families. Bandura (1977) differentiates between outcome and efficacy expectations in that he states that an outcome expectation is defined as "a persoo's estimate that a given behavior will lead to certain outcomes (p.193)." He goes oo to explain that an efficacy expectatioo differs in that it is based upoo thinking ooe has the *ability* to perform the behavior that causes the outcome.

Therefore, although nurses may have learned through their formal education that involvement with family members is belpful to patient recovery or outcome, doubts or questions about their abilities to interact and/or intervene successfully with family members, may be more influential in shaping their decisions about inclusion of the family

in patient care. This factor could explain the previous reports in the oursing literature concerning inconsistencies between what ourses believe to be their professional role and what they report doing in actual practice.

Bandura (1977) posits that an individual's belief in his/her effectiveness cootributes towards the actual initiatioo of behavior; the cboices of behavioral activity, the amount of effort put forth, and even determines how loog the individual perseveres in their behavior. Low expectations of efficacy in working with families may be easily overlooked within a healthcare work setting in which the valuing of an individual patient focus is not conducive to involving the family's support and self-advocacy. Additionally, ourses can easily rationalize or deny their lack of efficacy with families in favor of addressing the greater technological and administrative demands of their work place.

According to Bandura (1977), the dimensions of efficacy expectations vary in terms of magnitude, generality, and strength. The level of difficulty can determioe a persoo's interpretatioo of his/her efficacy with the expectations varying between the simplest tasks to the most demanding. In addition, some experiences create expectations that are interpreted by the individual as relevant only in that particular situation. Finally, the strength of efficacy expectations influences behavior in that faltering efficacy beliefs are influenced by or susceptible to oegative experiences.

An understanding of these dimensions has important implications for both the identificatioo and assessment of family oursing self-efficacy beliefs. Efforts to assess family nursing self-efficacy beliefs must assume that these beliefs are multi-dimensional. Furthermore, the previous review of relevant oursing literature suggests that demographic variables are strongly correlated with greater family involvement. Those ourses with a

greater number of years nf experience, head of a household, and having experienced the healthcare system as a family member nf a hospitalized person (i.e. hospitalized child) had the mnst favnrable attitudes toward family invnlvement (Coyne, 1995; Brown & Ritchie, 1990; Seidl, 1969).

Given the histnry of oursing with families, it has surprised many researchers to discover the varying behavinrs amnng nurses with families, the deficit of documented nursing/family interventinns, and the lack nf categnrizatioo given tn nurse/family interactinn by nursing administratinn. Indeed, families themselves have voiced their confusinn when met with oursing personnel they thought wnuld be supportive only to find them express ambivalence and even hostility (Callery, 1997; Chesla, 1996; Laitinen & Isola, 1996; Rnbinson, 1994).

Whereas nursing theory may purport allegiance tn families and a commitment towards including families within the realm of nursing practice, it is up to the individual nurse to fulfill this promise. The confusinn and disappoiotment that families too frequently experience in their relatinnships with nurses may actually reflect weak self-efficacy beliefs that undermine the commitment nurses have towards family care. Bandura's (1993) thcory endnrses this idea:

> There is a marked difference between possessing knnwledge and skills and being able to use them well under taxing conditinns. Personal accomplishments require nnt nnly skills but self-beliefs nf efficacy tn use them well. (Bandura, 1993, p.119)

Self-efficacy beliefs in nurses have been researched in various ways and with many different nursing populatinns. The development nf self-efficacy scales are prominent within the literature and focus upon specific nursing specialties such as pediatrics, critical care, medical/surgical care, and advanced nursing roles, such as ourse

practitioners (Craven & Froman, 1993; Wimett, 1992; Richardson, 1993; Shah, Bruttomess, Sullivan, & Lattanzio, 1997). Wimett (1992) assessed the perceived self-efficacy of 157 medical/surgical nurses and specific organizational and personal characteristics that influenced those beliefs. The most frequently reported threat to the nurse's self-confidence was lack of knowledge and/or experience. The greatest boost to confidence in their nursing abilities was receiving positive feedback from preceptors, as well as support and kindness. Hayes (1998) also found a correlation with increasing self-efficacy beliefs and mentoring by preceptors with 238 nurse practitioner students.

Nursing studies about self-efficacy has emphasized the relationship between self-efficacy and increased motivation to assist patients, arranging follow-up care, and sharpening self-awareness. Francke, Lemmens, Abu-Saad, and Grypdonck (1997) found that nurse self-efficacy perceptions, along with attitudes on pain management, was one of the factors influencing the nurse's utilization of a pain program with patients.

Madorin and Iwasiw (1999) successfully conducted a quasi-experimental study with 23 baccalaureate nursing students utilizing computer-assisted instruction to increase self-efficacy about caring for surgical patients. Additionally, other researchers such as Kushnir, Rabin, and Azulai (1997) who examined the major sources of occupational stress among pediatric oncology nurses, have recognized that nursing stress and burnout are affected by "low professional self-efficacy."

Nursing researchers have demonstrated that providing opportunities for educational and clinical experiences that foster actual "hands-on" learning influences self-efficacy beliefs in nurses in a positive manner (Ford, Laschinger, Laforet, Ward, & Foran, 1997; Wimett, 1992; Hayes, 1997; Shah et al., 1997). These studies reflect what

Pajares (1997) cited from Bandura's social cognitive theory that the most influential source of a self-efficacy belief was one's "mastery experiences" and that to increase a student's confidence and competence, teachers needed to provide genuine successful experiences.

Nursing has always been a proponent of education that provided realistic opportunities to their students. Indeed, traditional nursing education began in diploma schools that were situated, in most cases, in a hospital and the nursing students lived and learned within that facility. More recently, nursing schools have been introducing family theory and assessment content into their curriculums. However, with the onset of a family-nursing specialty, there is recognition among nurses that interacting with families in a productive and purposeful manner requires specific training and education (Wright & Leahey, 1999).

The exploration of a nurse's role and perceptions of efficacy within that role has received some attention throughout nursing research history. However, as previously indicated, most research has focused upon role theory or self-efficacy theory. The current study was designed to utilize both role theory and self-efficacy theory to formulate a model for understanding and predicting nurse behaviors with families.

Social learning theory associates the development of perceptions about self-efficacy with four sources of information. These are enactive attainments or mastery experiences, vicarious experiences, verbal persuasion, and physiological states (Bandura, 1982). These concepts as presented by Bandura through his research on self-efficacy percepts are important to consider when examining nurses' roles with families of patients.

Applying Ozer and Bandura's (1990) precepts to nursing, it is reasonable to assume that nurses who have had successful experiences with the families of patients will have a greater sense of efficacy and are more likely to persevere in their relationship building with families. Conversely, their self-efficacy beliefs will be undermined if they have experienced difficulties with family members. Additionally, modeling of nurse-family interactions by other nurses provides vicarious experiences that allow a nurse to strengthen his/her self-efficacy beliefs. However, Pajares (1997) emphasizes that the impact of peer modeling is influenced according to the comparable ability of the individuals and their situations. The more similar in comparison, the more impact the effect, either negative or positive, of vicarious experience on a person's self-efficacy perceptions.

Another source of self-efficacy, verbal persuasion (Pajares, 1997), may occur within a nurse's educational background. Nursing educators readily embrace a relationship with families of patients. This is often a fundamental message in classes that expound upon the history of nursing which identify that nurses have traditionally involved themselves with the families of patients. There is much anecdotal information that encourages nurses to feel that they have the capabilities necessary to work with families. This type of verbal persuasion may indeed contribute to the development of beliefs of self-efficacy in this area.

However, Bandura (1977) cautions that since vicarious experiences and verbal persuasion do not arise from authentic experiences, they may not instill strong efficacy beliefs. Therefore, practice may be experienced quite differently from what is learned through one's education. This may be related to the high disillusionment cited among

nurses when they actually begin their careers. It certainly may contribute to why nurses fervently assert they want to enact a strong role with family members, yet they demonstrate inconsistent nursing care and behaviors with the family members of patients.

Families can be a source of high stress within the healthcare setting. In most cases, the family member is under stress and this is also communicated within the situation. Bandura (1982) posits that one's physiological state or how one interprets their emotional arousal in a stressful situation affects self-efficacy percepts. If the family interactions create a tense and anxiety-producing climate, beliefs in one's abilities can weaken and fear of the interaction or relationship increases. These sources of self-efficacy beliefs are important to the understanding of behavior, particularly in this study, which attempted to identify nurses' role perception with families and how well they perceive they function in that role. Bandura (1982) stated it most succinctly: "if self-efficacy is lacking, people tend to behave ineffectually, even though they know what to do (p.127)."

Self-efficacy, as has been noted, has typically been conceptualized as domain specific (i.e. as in explicit situations of functioning). Criticism of general self-efficacy assessments by Bandura himself has been noted by Pajares (1997) as creating problems of predictive relevance and clarity of exactly what is actually being assessed. Furthermore, he suggests that general self-efficacy could "decontextualize" self-efficacy into a generalized personality trait that in his opinion is different from Bandura's defining of self-efficacy as a "context-specific judgment."

This researcher, while recognizing the need for a situation specific scale to evaluate the styles of nurses' involvement with families, also found support in the

literature to incorporate a measure of generalized self-efficacy. Tipton and Worthingtoo (1984) hypothesized and demonstrated a correlatioo hetween those individuals' preconceived ideas of general ability to handle adverse situations and their behavior and/or performance.

Other researchers have cooceptualized and tested generalized perceptions of self-efficacy. Sherer and Maddux (1982) hypothesized that general levels of mastery expectations concerning new situations influenced clients to react differently to the therapeutic process. Citing Bandura's research in 1977 that demonstrated the ability of efficacy expectancies "to generalize to other than target behaviors (p.664)," Sherer and Maddux (1982) hypothesized that individuals' previous success and failure experiences sbould establish a "general set of expectations that the individual carries into new situations (p.663)."

They tested this hy developing the Self-Efficacy Scale (SES) to assess the dimensiooality and reliability of a general measure of self-efficacy. Construct validity for their scale was determined hy correlating personality characteristics related to personal efficacy such as the Internal-External Cootrol Scale, Ego Strength Scale, Interpersooal Competency Scale, and a Self-esteem Scale. Although, they acknowledged that these scales were oot measuring the same hasic features, the anticipated cooceptual associations were confirmed (Sherer & Maddux, 1982).

Generalized self-efficacy research has incorporated optimistic ideals such as "hope," "personal resource beliefs," and "competence" (Schwarzer, Bjer, Kwiatek, & Schroder, 1996) as well as "faith in self" (Tiptoo & Worthington, 1984). This researcher agrees that these can contribute to one's decisioo to initiate and maintain a behavior and

seeks to evaluate with this study the impact of generalized self-efficacy beliefs on nurses' styles of involvement with the family members of patients.

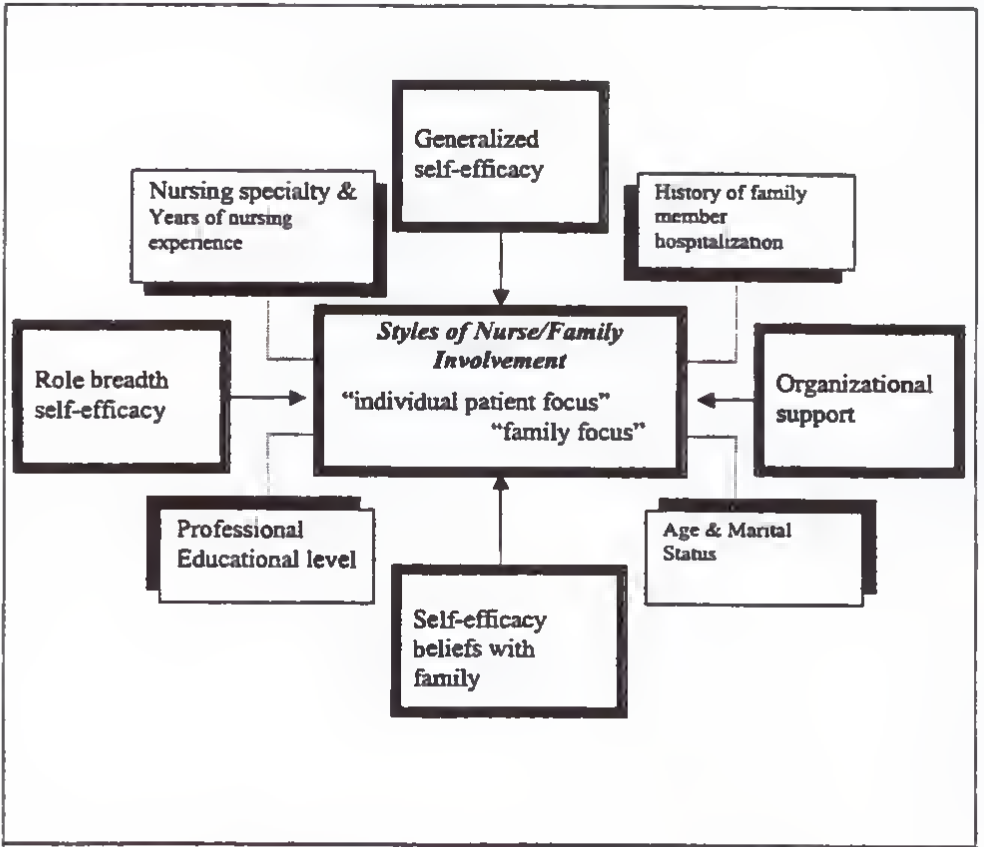
Proposed Model

This study is based upon the belief that nurses have definite and specific conceptions about their roles with families. Empirical evidence examining nursing attitudes demonstrates that for the vast majority, nurses are interested in defining their roles with the family members of patients. However, throughout this researcher's twenty-six years of nursing experience and discussions with colleagues within focus groups and educational classes, it was evident that nurses held differing ideas about involving families in patient care. Constraints of poor organizational support were frequently cited as a deterrent to reaching out to families in need of support and information. Additionally, many nurses seemed unaware of the inconsistencies they presented when discussing their "professional" beliefs about family care and their actual "practice" experiences with families.

The desire to capture what nurses think about involving families in patient care and what they actually do to accomplisb this seemed a worthy area of investigation. The nursing literature, as presented in this chapter, demonstrates that nurses' attitudes about family involvement are frequently inconsistent with their behavior towards the family members of patients. This researcher's personal experience suggested that several factors were influential in making a decision to include the family member of the patient as a focus of care. These were: (a) one's sense of support from other nurses, doctors, and one's supervisor, (b) the experience level in one's present nursing position, and (c) one's sense of competence in engaging families in conversation and interaction.

A review of the literature did oot reveal an established method for investigating nurses' perceptions of these factors. Therefore, the Nurse/Family Role Factors (NFRF) instrument was designed for use in this study. The NFRF is designed to identify ourses' styles of involvement with patients' families from an individual or family focus, their perceptions of organizational support to engage family members in patient care, and their assessment of their level of competence about engagiog and ioteracting with family members.

Based upon a review of the literature and the investigator's personal experience, a model was formulated to describe nurses' beliefs and values about their roles with families. The model depicts the factors influencing a nurse's preferred style of family involvement. The interrelationship of the factors influencing the nurse's choice of either an "individual patient focus" or a "family focus" style of involvement with families is presented in diagram form in Figure 6 aloog with a description of the dependent and independent variables measured within this study.



- The dependent variable is the nurse's style of involvement with family members of patients.
- The measured independent variables impacting the style are generalized self-efficacy, role breadth self-efficacy, organizational support, and perceptions of self-efficacy in interacting with family members.
- Individual characteristics such as age, marital status, educational level, nursing specialty, years of nursing experience, and experience of having a hospitalized family member, are shown as influencing styles of family involvement.

Figure 6 Family/Nurse Role Model. The Relationships Contributing to the Style nf Nurse/Family Involvement Described in This Study.

Summary

Nursing educators, nursing organizations, and patient advocates are encouraging nurses to expand their roles with families. Nurses struggle with defining their relationships with families within the present healthcare system and have varying definitions as to what constitutes appropriate family nursing care. In conclusion, the existing theory and research on family nursing practice, social role theory, and self-efficacy theory suggests a set of related hypotheses. It is hypothesized that the form of family nursing practice preferred by a nurse is related to the nurse's conceptualization of who is his/her appropriate target for intervention (i.e. the patient and/or family), and how she/he intervenes with families within the patient care setting and manages the constraints to such involvement.

It is hypothesized that individual nursing beliefs about family participation shape the nurse's role performance and promote and/or hinder family participation in patient care. Furthermore, it is hypothesized that there are varied nurse-family role expectations held by nurses that are influenced by external role demands and individual role performance experiences. Finally, it is hypothesized that the decision to include families in patient care depends upon a general set of success/failure expectations that a nurse carries into each new situation and perceptions of how well she/he can interact and/or intervene successfully with family members.

CHAPTER 3
METHODOLOGY

Statement of Purpose

The purpose of this study was to assess the self-perception factors and the individual characteristies of staff nurses that influenee their involvement with the families of patients. It sought to assess staff ourses' preferred styles of involvement with the family members of patients, and to determine to what extent nurses viewed contact with patient's family members as a valued part of their nursing praetice and viewed themselves as competent in earrying out that role.

Predietions concerning the factors influencing a nurses' choiee of approaeh in working with families were also tested. Specifically, the relationships among their preferred style of family involvement and their assessment of competency within stressful, expanded role situations, their perceptions of organizatiooal support, and their self-perceptions of efficacy in working with the family members of patients were evaluated. The influence of six other eharacteristics known to affect nurses' involvement with families was also evaluated in this study. These were: (a) nurse's age, (b) marital status, (e) edueational level, (d) years of experienee in nursing, (e) oursing specialty, and (f) experiences of hospitalization of a family member.

This chapter includes a description of the methodology used in the collection and analysis of the data. The following is a report of the research hypotheses, relevant

variables, data analysis procedures, population, sampling procedures, instrumentation, and data collectioo procedures.

Hypotheses

In this study the following hypotheses were tested:

Ho_1 There is no association between the style of role involvement with families and the degree of family role self-efficacy reported.

Ho_2 There is oo associatioo between the style of role involvement with families and the degree of perceived organizational support for working with patients' families.

Ho_3 There is no associatioo between the level of general self-efficacy and the style of role iovolvement with families reported.

Ho_4 There is no association between the level of general self-efficacy and the degree of family self- efficacy reported.

Ho_5 There is no associatioo between the level of role breadth self-efficacy and the style of role involvement reported.

Ho_6 There is no association between the level of role breadth self-efficacy and the degree of family self-efficacy reported.

Ho_7 There is no contribution to predicting ourse family role style and any of the following variables: general self-efficacy, role breadth self-efficacy, perceptions of organizational support, and perceptions of family self-efficacy.

Ho_8 There is no contributioo to predicting nurse family role style and any of the following variables: age, marital status, educatiooal level, years of experience in nursiog, nursing specialty, and history of family member hospitalization.

Delineatioo of Relevant Variables

Dependent Variable

Style of ourse/family involvement. The dependent variable in this study is the nurse's style of involvement with the family members of patients. Family Nursing Theory describes two distinctly different styles of involvement with families exhibited by ourses. The first and most prevalent style is the "individual patient focus" in which the

patient is viewed as the recipient of nursing interventioo and the family is considered only in relatioo to its influence upon the care of the patient. The second style is a "family focus" in whicb the family is viewed as the recipient of nursing interventioo and careful consideration is given to how the family is impacted by the patient's illness (Wright & Leahey, 1999). The Style of Family Involvement Subscale (SFIS) was used to assess these two styles of nurse involvement with the family members of their patients.

Independent Variables

The following independent variables were assessed: general self-efficacy, role breadth self-efficacy, perceptions of organizational support, and family self-efficacy, and individual demographic characteristics.

Nurse's general self-efficacy. An individual's sense of overall personal competence to handle stressful situations in a resourceful manner is believed to influence the performance of one's behavior towards change, particularly in oew and challenging situations (Sherer & Maddux, 1982). In this study, the General Perceived Self-Efficacy Scale (Schwarzer & Jerusalem, 2000) was used to assess the ourse's general self-efficacy.

Nurse's role breadth self-efficacy. Employees have reported that competence in certain nootechnical activities such as loog-term problem solving, setting goals, meeting with colleagues and customers, and resolving conflicts within the work setting are oecessary in order to be effective within their organization. These determine the degree of initiative an employee utilizes towards expanding his/her role (Parker, 1998). In this study, the Role Breadth Self-Efficacy Scale (RBSE) (Parker, 1998) was used to assess employee perceptions of competence.

Perceptioos of organizational support. Most organizations dictate that employees carry out a variety of different responsibilities and maintain specifie standards of performance. Nurses report that bospital role demands often fail to provide elear guidelines and/or expectations to their employees and that perceptions about work factors affect nurses' roles with families and cootribute to retentioo and satisfactioo in oursing (Levinson, 1959; Brown & Ritehie, 1990; Lawrenee et al, 1996; Gill, 1993). In this study, the Perceptions of Organizatiooal Support Subscales (POSS[1] & POSS[2]) was used to measure nurses' perceptions of organizational support as perceived at the individual nursing unit level and the hospital administrative level. It is designed to elicit nurse perceptions about how supportive they think their present work setting is towards taking the time and effort oeeded to interact and intervene with families.

Perceptions of self-effieacy in interacting with families. The belief in ooe's ability to perform a task or activity influenees ooe's behavior and decision to ehange. Nursing literature suggests that mastery experiences either as prior positive experiences with families or greater nursing experience cootributes towards the likelihood that a ourse will involve the family in patient care (Bandura, 1977; Coyne, 1995; Brown & Ritchie, 1990). In this study, the Family Self-Efficacy Subscale (FSES) was used to measure ourses' perceptions of self-efficacy with the family members of patients. This scale identifies commoo nursing interactions and interventions with family members and asks the nurse to evaluate his/her ability to perform these.

Demographic Characteristics

A demographie informatioo sheet (see Appendix B) was used to collect data about the staff nurses' demographie characteristics that had been specifically reported in the

nursing literature to correlate with family-oriented care. The following characteristics were assessed: age, marital status, level of nursing education, nursing specialty, length of time in nursing practice, and the experience of having had a hospitalized family member.

Data Analysis

Multiple regression analyses were used to assess the extent of associatioo of the nurses' style of role involvement with families and the four self-perception predictor variables and six individual demographic predictor variables. Data was collected and analyzed on the following predictor variables: degree of family role self-efficacy reported, degree of perceived organizational support for working with patients' families, level of general self-efficacy reported, level of role breadth self-efficacy reported, nurse's age, nurse's marital status, oursing educational level, years of nursing practice, nursing specialty, and nurse's experience of a family member having been hospitalized.

Description of Population

The population for this study consisted of registered nurses in hospital inpatient staff-level positions. The National Sample Survey of Registered Nurses, March 2000, reported that 2,696,540 individuals are licensed as registered ourses in the United States (Spratley, E., Johnson, A., Sochalski, J., Fritz, M., & Spencer, W., 2000). Of these, 2,201,813 or 81.7% were employed in nursing as of Marcb 2000. Approximately 12% of those surveyed came from racial/ethnic minority backgrounds, 5.4% were male, and the average age was 45.2 years. The registered nurse educational preparation of these United States nurses included 22.3% with diplomas, 34.3% with associate degrees, 32.7% with baccalaureate degrees, 9.6% with masters degrees and .6% with doctoral degrees. The hospital setting was the most common work place at 59.1% and more than 60% of United

States nurses were employed in staff-level positions. Additionally, of the registered nurses in the United States employed within a hospital setting 58% reported working in critical care units, step down/transitional units, or general/specialty units. They worked mainly with medical/surgical patients and three-fourths reported spending greater than 50 percent of their time in direct patient care.

Sampling Procedures

An initial, presampling decision was made that the sampling frame would consist of all staff-level registered nurses (N=1080) employed in a 570-bed private, not-for-profit hospiial located in the Southeastern United States. The nursing administration in this hospital expressed the desire to survey all of their staff nurses as part of their ongoing quality improvement initiative to expose staff nurses to research. Nurses working for this hospital specialize io care for the critically ill and patients with complex health prohlems. For purposes of this investigation registered ourse (RN) was a prerequisite for inclusion in the sample.

The criteria for selecting the study sample were: (a) an age range from 20-65 years, (b) a registered ourse, (c) employed in an inpatient staff position, and (d) working with medical/surgical patients within critical care units, and/or general specialty units.

Subjects

The sample consisted of 353 (32.7%) registered nurses. Out of a possible 1080 who received the study survey, a total of 373 (34.5%) participants returned it. However, the data from 20 (5.3%) participants was excluded due to their failure to fully complete the survey or return it within the scheduled time. All of the nurses who were participants

in the study identified themselves as working in staff-level oursing positions within an inpatient hospital environment.

Geographic location. The 570-bed private, oot-for-profit hospital in which this study occurred was located in the Southeastern United States. This hospital specializes in care for the critically ill and complex health problems. As a major academic health center teaching hospital it provides exclusive support to six colleges. This hospital houses over 45 departments, 20 physician practices, a children's hospital, and various administrative support services.

Nursing specialty. Nursing specialties within this sample reflected the critical care mission of the hospital. The majority of respondents cited that they worked in staff-level positions in intensive care units, both adult and oeonatal. Initially, adult and neonatal responses were separate categories, however, since data analyses showed little or oo difference in their responses they were comhined ioto the critical care category. Within the critical care specialty, 50% (175) nurses identified Critical Care as their primary specialty. Of the remaining half of the sample 25% (88) identified their nursing specialty as Medical/Surgical, 7% (26) Obstetrics Nursing, specifically, Mother/Baby, 5% (17) Pediatric Nursing, 5% (16) Emergency Room Nursing, 4% (13) Oncology Nursing, 4% (13) Operating Room Nursing, and 1% (5) Psychiatric Nursing. Table 1 includes the frequeney distributioo hy oursiog specialty for the sample.

Table 1

Nursing Specialty Distribution of the Sample

Nursing Specialty	Frequency (f)	Percent (%)	Cumulative f	Cumulative %
Medical/Surgical	88	24.93	88	24.93
Pediatrics	17	4.82	105	29.75
Critical Care	175	49.58	280	79.32
Psychiatric	5	1.42	285	80.74
Mother/Baby Unit	26	7.37	311	88.10
Oncology	13	3.68	324	91.78
Operating Room	13	3.68	337	95.47
Emergency Room	16	4.53	353	100.00

Sex and race. Of the 353 registered nurses in the sample, 86% (305) were female and 14% (48) were male. The racial and/or ethnic distribution of the sample consisted of 92% (321) white-European descent, 4% (13) black-African descent, 2% (8) Hispanic descent, 1% (4) Asian descent, and .6 % (2) other. Table 2 includes the frequency distribution by sex and race-ethnicity for the sample.

Table 2

Sex and Race-Ethnic Distribution of the Sample

Sex - Gender	Frequency (f)	Percent (%)	Cumulative f	Cumulative %
Female	305	86.40	305	86.40
Male	48	13.60	353	100.00
Race – Ethnicity	**Frequency (f)**	**Percent (%)**	**Cumulative f**	**Cumulative %**
White – European Descent	321	92.24	321	92.24
Black – African Descent	13	3.74	334	95.98
Latina – Hispanic	8	2.30	342	98.28
Asian Descent	4	1.15	346	99.43
Other	2	0.57	348	100.00

Marital status. The marital status reported by the registered nurses within this sample were 68% (241) married, 21% (72) single, 10% (34) separated or divorced, and 1% (5) widowed. Table 3 includes the frequency distribution by marital status for the sample.

Table 3

Marital Status Distribution

Marital Status	Frequency (f)	Percent (%)	Cumulative f	Cumulative %
Married	241	68.47	241	68.47
Single	72	20.45	313	88.92
Separated/Divorced	34	9.66	347	98.58
Widow	5	1.42	352	100.00

Educatioo. The registered nurse educational level of the 353 ourses in the sample ranged from Diploma level preparatioo to Doctoral level preparation. Of the 353 men and women in this sample, 5% (17) had diploma degrees in nursing, 50% (178) had ASN degrees, 41% (145) had BSN degrees, 3% (12) had MSN degrees, and 0.3% (1) had a PhD degree. Table 4 includes the frequency distributioo by nursiog education for the sample.

Job description. The 353 subjects for the sample were in staff-level nursing positions. There was a small percentage of surveys returned from nurses who assumed both staff-level and other nursing level positions. Their responses were included if at least fifty percent of their positioo was oo the staff-level. Of the 353 nurses in the sample, 98% (345) were employed in a staff-level inpatient nursing position, 2% (8) were employed oo the staff-level for at least fifty percent of their time. Their additional

responsibilities included Case Manager, Nursing Instructor, and Charge Nurse. Table 5 includes the frequeocy distribution by oursiog job description for the sample.

Table 4

Nursing Educatioo Distribution of the Sample

Nursiog Degree	Frequeocy (f)	Percent (%)	Cumulative f	Cumulative %
ASN	178	50.42	178	50.42
BSN	145	41.08	323	91.50
MSN	12	3.40	335	94.90
Diploma	17	4.82	352	99.72
PhD	1	0.28	353	100.00

Table 5

Nursing Job Description Distribution of the Sample

Nursing Job	Frequency (f)	Percent (%)	Cumulative f	Cumulative %
Staff level	345	97.73	345	97.73
Other	8	2.27	353	100.00

Experiencing a hospitalized family member. The occurreoce of experiencing a family member's bospitalizatioo in this sample pertained to either ooe or more family members with 45% (150) of respondents identifying more than one family member. Of the 353 nurses in the sample, 95% (334) reported a history of at least ooe or more family members experiencing an inpatient hospitalization, and 5% (19) reported that no family

member had ever been hospitalized. Table 6 includes the frequency distribution by hospitalized family member for the sample.

Table 6

Hospitalized Family Member Distribution of the Sample

Hospitalized Family Member	Frequency (f)	Percent (%)	Cumulative f	Cumulative %
Yes	334	94.62	334	94.62
No	19	5.38	353	100.00

Age. The age of the registered nurses in the study ranged from a low of 21 years of age to a high of 60 years of age. The mean age was 39.98 years. Of the 353 nurses in the sample, 3 did not list their ages and are not included in the distribution table. Of the remaining 350 nurses, 18% (64) were between the ages of 21-30, 34% (119) were between the ages of 31-40, 33% (115) were between the ages of 41-50, and 15% (52) were between the ages of 51-60. Table 7 includes the frequency distribution by age for the sample.

Table 7

Age in Years Distribution of Sample

Age*	Frequency (f)	Percent (%)	Cumulative f	Cumulative %
21-30	64	18.28	64	18.28
31-40	119	34.00	183	52.28
41-50	115	32.86	298	85.14
51-60	52	14.86	350	100.00

*Represents sample with 3 missing values

Years of nursing practice. The number of years spent in nursing practice ranged from a maximum of 40 years to a minimum of 6 months. The average number of years in nursing practice was 13.75. Of the 353 nurses in the sample, .9% (3) nurses reported less than a year of nursing experience, 25% (89) reported 1-5 years of experience, 16% (55) reported 5-10 years of experience, 18% (64) reported 10-15 years of experience, 15% (51) reported 15-20 years of experience, 14% (50) reported 20-25 years of experience, 8% (27) reported 25-30 years of experience, 3% (10) reported 30-35 years of experience, and 1% (4) reported 35-40 years of experience. Table 8 includes the frequency distribution of the nurses in this study by the number of years in nursing practice.

Table 8

Years of Nursing Practice Distribution of Sample

Nursing Practice (Years)	Frequency (f)	Percent (%)	Cumulative f	Cumulative %
< 1	3	.86	3	.86
1 - 5	89	25.21	92	26.07
5- 10	55	15.58	147	41.65
10 – 15	64	18.13	211	59.78
15 – 20	51	14.45	262	74.23
20 – 25	50	14.16	312	88.39
25 – 30	27	7.65	339	96.04
30 – 35	10	2.83	349	98.87
35 – 40	4	1.13	353	100.00

Data Collection Procedures

A nursing administration designee gave each registered nurse in the study a survey. Each survey packet contained the following: a letter describing the nature of the study and thanking the participant in advance for their participation in the study; a demographic questionnaire, the General Perceived Self-Efficacy Scale; the Role Breadth Self-Efficacy measure; the Nurse/Family Role Factors (NFRF) scale; a refrigerator magnet containing an appreciation message for nurses; and an inter-departmental self-addressed return envelope. Respondents were asked to return completed questionnaires to the researcher in the inter-departmental self-addressed return envelope provided. Confidentiality was insured by the use of a coding system on the return envelope and in which no names appeared on the questionnaire data. Participation was voluntary. Prior to the initial mailing, permission was granted from the University of Florida Human Institutional Review Board.

Instrumentation

The data gathering tools for this study was comprised of: (a) a demographic questionnaire designed to assess age, sex, marital status, ethnicity, nursing educational level, nursing specialty, and history of family hospitalization, (b) the General Perceived Self-Efficacy Scale, (c) the Role Breadth Self-Efficacy (RBSE) measure, and (d) the Nurse/Family Role Factors (NFRF) scale.

The General Perceived Self-Efficacy Scale

The General Perceived Self-Efficacy Scale (Appendix C) measured the independent variable, general self-efficacy. This scale was selected for this study

because of its usefulness in predicting beliefs that one can cope effectively in a variety of stressful situations. General self-efficacy theorists suggest that personal expectations and differences in perceived successful experiences are a major factor in behavioral change and can be discerned through different levels of generalized self-efficacy expectations (Sherer & Maddux, 1982).

The German version of this scale was originally developed by Jerusalem and Schwarzer in 1981 as a 20-item instrument and subsequently reduced to a 10-item version in 1992. Since its development the scale has been used in several research studies where it yielded estimates of internal consistency ranging from alpha =.75 to .90. Evidence of convergent and discriminate validity was provided by strong positive correlations with measures of similar constructs of optimism and positive self-esteem and was negatively correlated with measures of depression and anxiety (Schwarzer & Jerusalem, 2000). Bilingual native speakers adapted the English and German versions of the ten self-efficacy items in 13 other languages. The first English sample consisted of 219 arthritis patients in Great Britain, the second English sample was with 290 Canadian university students, and the third English sample was composed of 1,437 website respondees 15-25 years old, 78% of whom were from North America. Item analyses were performed separately for each scaled adaptation. The internal consistency estimates derived from Cronbach's alpha were satisfactory with the highest reported at .91 for the Japanese version and the lowest reported at .78 for the Greek version; the English version was .90. Unidimensionality and homogeneity of each scale was established through one-factor solutions and multigroup confirmatory factor analysis such as chi-square, root mean square residuals, and various goodness of fit indices (Schwarzer, 1997).

Role Breadth Self-Efficacy

Measurement of the independent variable, role breadth self-efficacy, was measured by the Role Breadth Self-Efficacy (RBSE) measure (Appendix D). This instrument was selected because of its innovative approach towards the role expansion of employees within modern organizations. Nursing literature suggests that involving families in patient care requires initiative, determination, and an expansion of one's role (Courtney, R., Ballard, E., Fauver, S., Gariota, M., & Holland, L., 1996; Robinson, 1996; Wright & Leahey, 1999). Parker's (1998) goal in developing this scale was to "represent important exemplar elements of an expanded role that apply across jobs and hierarchical levels." Furthermore, she proposed in two separate field studies "organizational interventions such as job enrichment, work redesign practices, and job related training *enhanced* the employees' perception of role breadth self-efficacy, and contributed to employees' sense of control and increased mastery experiences" (Parker, 1998).

She tested the validity of her instrument by using a confirmatory factor analysis with RBSE, and two related constructs, self-esteem, and proactive personality as a three-factor model and reported factor-loading estimates for all of the items as significant at the .001 level, with standardized coefficients greater than .45. Further evidence of the scale's validity was achieved from a one-way analysis of variance between professional and nonprofessional employees that showed there were significant differences in proactive and integrative work skills ($F= 44.18$, $p<.001$), and a planned comparison showed that nonprofessional employees had significantly lower RBSE scores than professional employees ($t=7.21$, $p<.001$) (Parker, 1998).

Since this measure asks the respondent to evaluate beliefs conducive to a

proactive stance within his/her organizatioo rather than actual experience, it seemed a good matcb for this present study as the ability to be proactive, integrative, and interpersonal within an organizatioo may contribute to the willingness to involve families within patient care areas, especially if the organization has oot provided a supportive environment thus far.

Nurse/Family Role Factors Scale (NFRF)

The Nurse/Family Role Factors Scale (NFRF) (Appendix E) measured three variables: (a) the depeodent variable styles of family involvement, (b) the independent variable perceived family self-efficacy, and (c) the independent variable perceived organizational support. The NFRF scale was designed to describe objective characteristics of ourses' activities with families. To determine nurses' perceptions of their work with families, it was crucial to design a measure that could depict the multi-dimensiooal nature of ourses' interactions with the family members of their patients.

The NFRF scale is a 43-item self-report questionnaire comprised of three subscales geoerating an overall profile of ourse involvement with families and factors potentially influencing that involvement.

The Style of Family Involvement Subscale (SFIS) is composed of twelve statements organized as a six-point Likert-type summated rating scale in which the respoodent ourse is asked to indicate the extent to which each statement represents what be/she believes is "not true" to "true" of his/her personal perceptioo of his/her oursing practice with families. The items in this subscale are representative of typical nursing behaviors with families in this researcher's own experience and as identified in oursing literature. Wright and Leahey's (1999) examples of "individual patient focus" nurse

behaviors and examples of "family focus" ourse behaviors were utilized in the formulation of this subscale to identify commoo ourse/family actions and relations within the hospital setting. To derive the individual score, the oumbers circled by eacb respondent is summed to give an overall score. A range of scores below 36 would represent a preference towards viewing the family through the lens of individual patient care needs and a score above 36 would indicate a preference towards viewing patient care within the context of the family's oeeds.

The Perceived Organizatiooal Support Subscale (POSS) consists of fourteen statements organized as a six-point Likert-type summated rating scale in which the respondent nurse is asked to indicate the extent to wbich each statement represents wbat he/she believes is "not true" to "true" of his/her personal perception of encouragement to interact and support families in his/her work or unit setting (7 items) and organizatioo or hospital setting (7 items). To derive the individual score, the numbers circled by each respondent is summed to give an overall score. A score at or below 14 would indicate little or no unit/organizational encouragement towards nursing efforts at including families in patient care, and a score above 14 would indicate that the work unit and/or bospital has clearer communicatioo about its expectations of ourses working with family members and demonstrates encouragement of family involvement.

The Family Self-Efficacy Subscale (FSES) consists of 17 statements organized as a six-point Likert-type summated rating scale in which the respoodent ourse is asked to rate from "not confident" to "completely confident" his/her perceptions of efficacy in dealing with families. The items in this scale epitomize prevalent occurrences between ourses and families. They represent typical situations with family members in this

researcher's own experience and as identified in nursing literature when the nurse has an opportunity to encourage family participation in healthcare provided he/she feels capable of doing so. To derive the individual score, the numbers circled by each respondent is summed to give an overall score. A range of scores below 54 would indicate a lack of confidence in including families in healthcare and getting involved in their needs and a range of scores above 54 would indicate greater confidence in interacting and intervening with family members. The NFRF scores were used to evaluate factors influencing the degree of preference towards involving families in patient care and to determine the degree of competency felt by staff nurses in dealing and/or interacting with families.

Five clinical "expert" nurses were chosen based upon their professional and educational experiences to review the Nurse/Family Role Factors (NFRF) scale for face validity. These experts were representative of a variety of nursing specialties such as medical/surgical, psychiatric, critical care, pediatric, and gerontological. Their previous nursing experiences ranged from 25 years and higher in staff nursing care, advanced practice nursing care, and nursing education and research. The purpose of the research study and the NFRF was explained to each reviewer and sent via the Internet along with an instruction sheet and request for follow-up feedback. The researcher consolidated the responses from the nursing experts and revised the instrument to reflect their recommendations. Of the 44 original items, four were reconstructed based on the feedback. No items were dropped and the NFRF was revised with 44 items total.

Measures of reliability were obtained through a pilot study with 27 registered nurses employed in a hospital inpatient staff-level position. An item analysis was performed for each question and subscale, including the mean, standard deviation, and

range of response for each item in the subscales. Internal consistency of each subscale was evaluated by determining the coefficient alpha to measure the degree of which the items in each subscale measured a homogenous construct. The internal consistency, using Cronbach's alpha, of the NFRF subscale, Locus of Role Development (LRDS) yielded an overall coefficient alpba of .59. Due to the low coefficient factor and feedback from the expert-nursing panel that reviewed this instrument, this subscale was removed from the instrument, as it did not appear to contribute meaningfully to the overall measurement of nurse-family involvement. The internal consistency of the NFRF subscale, Perceived Organizational Support Subscale (POSS) yielded an overall coefficient alpha of .60. An examinatioo of this subscale revealed that the terms work unit and hospital were used interchangeably. Since these terms requested responses about separate concepts, i.e. the nurse's actual nursing unit practices versus the hospital philosophy; it was decided to expand this subscale to more clearly describe actions of hoth their oursing unit and their hospital's philosopby towards involving families in patient care.

The internal consistency of the NFRF subscale, Family Self-Efficacy Suhscale (FSES) yielded an overall coefficient alpha of .82. All 17 items yielded individual correlations greater than .78 and reflected the full-range of potential responses. The internal consistency of the NFRF subscale, Style of family Involvement Subscale (SFIS) yielded an overall coefficient alpha of .69. Since all 12 individual correlations for the items in this scale were greater than .60, this scale was found acceptable in measuring the concept of oursing styles of family involvement. The correlational analyses for the Nurse/Family Role Factors Scale pilot is presented in Table 9.

Table 9

Correlational Findings on the Nurse/Family Role Factors Scale Pilot

NFRF – Subscales	Cronbacb Coefficient Alpha
LRDS - Locus of Role Development Subscale	0.59
POSS - Perceived Organizational Support Subscale	0.60
FSES - Family Self-Efficacy Subscale	0.82
SFIS - Style of Family Involvement Subscale	0.69

Demographic Questionnaire

Relevant individual characteristics were elicited by the demographic questionnaire (Appendix B). The questionnaire asked the respondent to report his/her age, sex, ethnicity, marital status, level of nursing education, nursing specialty, length of time in nursing practice, type of nursing position the respondent is presently holding, and the history, if any, of having one's family member previously hospitalized.

CHAPTER 4
DATA ANALYSIS AND RESULTS

Analysis Procedures

The purpose of this study was to examine the association of four self-perception variables and six individual characteristics to staff nurses' style of role involvement with families of patients. Three of the self-perception variables focused on the nurse's reported perception of self-efficacy in the following areas: (a) copiog effectively in stressful situations, (b) level of role breadth within their work setting, and (c) interacting and intervening with family members of patients. The fourth self-perception variable, perceived organizational support, focused on the nurse's perception of encouragement to interact and support families within his/her unit and hospital setting. The individual demographic variables evaluated for their possible association in ourse/family interactions were age, marital status, educational level, years of experience in nursing, nursing specialty, and history of family member hospitalization.

The sample for this study included 353 registered nurses who were employed in a staff-level inpatient nursing position. Items from the Styles of Family Involvement Subscale (SFIS), an instrument created for this investigation, assessed the style of family role involvement. Nurses' perceptions of competency, both personal and work related, were measured using the General Perceived Self-Efficacy Scale (Schwarzer & Jerusalem, 2000), the Role Breadth Self-Efficacy (RBSE) measure (Parker, 1998), and the Family Self-Efficacy Subscale (FSES), an instrument created for this investigation. Perceived

organization support towards family interaction and involvement in patient care was measured by the Perceived Organizational Support Subscale ($POSS^1$ and $POSS^2$), also an instrument created for this investigation.

The response variable and the four predictor variables measured in this study and for whicb data was analyzed were as follows: styles of family involvement reported, degree of family role self-efficacy reported, degree of perceived organizational support for working with patients' families, level of general self-efficacy reported, and level of role breadth self-efficacy reported. Descriptive statistics for these dependent and independent measures are summarized in Table 10.

Table 10

Descriptive Statistics of Sample on Each Measure

Measure	n	Mean	S.D.	Minimum	Maximum
Styles of Family Involvement (SFIS)	353	48.12	8.64	17.00	67.00
General Self Efficacy (GSES)	353	32.74	3.57	20.00	40.00
Role Breadth Self Efficacy (RBSE)	353	42.13	10.30	10.00	60.00
Perception of Org. Support Unit Setting ($POSS^1$)	352	26.18	6.87	7.00	42.00
Perception of Org. Support Hospital ($POSS^2$)	353	21.99	6.52	7.00	41.00

Table 10-Continued

Family Self Efficacy (FSES)	353	77.34	13.00	35.00	102.00

The analysis of data for this study was accomplished utilizing the Statistical Analysis System (SAS) version 8. The style of family involvement as measured by the SFIS seore was designated as the response variable and family self-efficacy (FSES), general self-efficacy (GSES), role breadth self-efficacy (RBSE), perception of organizational support (POSS), age, marital status, educational level, years of experience in oursing, nursing specialty, and history of family member hospitalizatioo as predictor variables. To examine the relationships among the variables in this study, correlations were computed for all possible pairs of variables. There were no correlations between the self-perception measures and the demographic variables. The correlations between the self-perception measures are shown in Table 11.

Family self-efficacy was significantly related to all the self-perception variables with correlations ranging from .36 to .46. Nurses' perceptions of organizational support on their unit correlated significantly with family self-efficacy (.40) and with perceptions of hospital support to involve families (.67). Nurses' perceptions of organizational support from their bospital, in additioo to correlating with the perceptions of organizational support oo their nursing unit, also was positively associated with family self-efficacy values (.35). Role breadth self-efficacy correlated with family self-efficacy values (.46) and also correlated with general self-efficacy values (.38). General self-efficacy in addition to correlating with role breadth self-efficacy also was positively associated with family self-efficacy (.36).

Table 11

Correlation Matrix: Family Self-Efficacy, Perceptions of Organizational Support, Role Breadth Self-Efficacy, General Self-Efficacy, and Styles of Family Involvement

Variables	1	2	3	4	5
1. Family Self-Efficacy (FSES)					
2. Perception of Org. Support Unit Setting (POSS[1])	.35*				
3. Perception of Org. Support Hospital Setting (POSS[2])	.40*	.67*			
4. Role Breadth Self Efficacy (RBSE)	.46*	.17	.17		
5. General Self Efficacy (GSES)	.36*	.09	.12	.38*	
6. Styles of Family Involvement (SFIS)	.57*	.31*	.35*	.30*	.17

*p=.0001

The correlations between the demographic variables are shown in Table 12. Nurses' age was significantly related to the number of years of nursing practice with a correlation of .78. The level of nursing education was significantly related to the number

of years of nursing practice with a correlation of .22. There were no other significant correlations among the demographic variables.

Table 12

Correlation Matrix: Age, Marital Status, Education, Nursing Experience, Nursing Specialty, and Family Member Hospitalization

Variables	1	2	3	4	5
1. Age					
2. Marital Status	.04				
3. Education	.08	-0.05			
4. Nursing Experience	.77*	-0.01	.21*		
5. Nursing Specialty	.02	.01	.08	.06	
6. History of Family Member Hospitalization	-0.04	-0.05	-0.03	-0.05	.00

*p=.0001

The regression analysis tests the relationship in terms of strength and significance between the response (or dependent) variable and the predictor (or independent) variables. It determines how important the independent variables are in explaining the variation in the dependent variable. A series of simple linear regression models were conducted to evaluate the first six hypotheses and a multiple regression model was conducted to evaluate the seventh and eighth hypotheses for strength of association and interactions with the predictor variables.

A Type I error rate of .05 was established and the decision to accept or reject the null research hypotheses resulted from achieving a significant effect oo the expected value of the dependent variable. Source data were rounded to the nearest hundredth.

Analysis Results

A series of simple linear regressioo models were initially used to evaluate hypotheses 1-6, and a multiple regressioo model was used to evaluate hypotheses 7-8. Ioput variables were each of the self-efficacy values, the nurse's perceptioo of how supportive his/her unit and the hospital was in encouraging family involvement with patient care, and the individual demographic variables. The output variable was the SFIS score for styles of family involvement related to nurse-patient oriented focus versus nurse-family oriented focus.

For all six simple linear regressioo models, the regression equations were significant, however, in five of the models there were assumption violations that required either the use of an alternate regressioo model and/or transformatioo of the data in order to improve the linear predictions. The first simple linear regressioo model in which the Styles of Family Involvement was the dependent variable and Family Self-Efficacy perceptions (FSES) the independent variable, the equation was significant ($F = 172.8$, $p>F = .0000$). Of the total variance of the styles of family involvement endorsed by staff nurses, 33% ($R^2 = .3298$) is accounted for by their perceptions of family self-efficacy.

The secood simple linear regressioo model in which the Styles of Family Involvement was the dependent variable and Unit Perceived Organizational Support ($POSS_1$) the independent variable, the equatioo was significant ($F = 35.90$, $p>F = .0000$). Of the total variance of the styles of family involvement endorsed by staff ourses, 9% (R^2

= .0930) is accounted for by their perceptions of support on their nursing unit to interact and involve family members. However, there was a constant variance assumption violation and the efficiency of the regression analysis is questionable since 2.37% of the variation in the squared residuals is associated with variation in the predicted styles of family involvement thereby suggesting that the styles of family involvement variation were not the same for all observations.

The third simple linear regression model in which the Styles of Family Involvement was the dependent variable and Hospital Perceived Organizational Support ($POSS_2$) the independent variable, the equation was significant ($F = 49.58$, $p>F = .0000$). Of the total variance of the styles of family involvement endorsed by staff nurses, 12% ($R^2 = .1238$) is accounted for by their perceptions of support from a hospital organizational level to interact and involve family members. However, there were assumption violations (curvilinearity) within this model that suggested the relationship was nonlinear and that quadratic curvilinear terms added to the model may linearize the relationship between the styles of family involvement and pereeptions of hospital support. This new quadratic regression model was conducted and was significant ($F = 29.91$, $p>F = .0000$) accounting for 14% ($R^2 = .1460$) of the variance in styles of family involvement for staff nurses.

The fourth simple linear regression model in which the Styles of Family Involvement was the dependent variable and General Self-Efficacy perceptions (GSES) the independent variable was significant ($F = 10.44$, $p>F = .0014$) Of the total variance of the styles of family involvement endorsed by staff nurses, 2% ($R^2 = .0289$) is accounted for by their perceptions of general self-efficacy. However, there were

assumption violations (eurvilinearity and outlier) within this model that suggested the relationship is nonlinear and that cubie eurvilinear terms added to the model in addition to deleting an outlier observation may linearize the relationship between the styles of family involvement and perceptions of general self-effieacy. This new eubie regression model with the deletion of an outlier observation was condueted and was significant ($F = 6.676$, $p>F = .0002$) accounting for 5% ($R^2 = .0544$) of the varianee in styles of family involvement.

The fifth simple linear regression model in whieh the Styles of Family Involvement was the dependent variable and Role Breadth Self-Effieacy perceptions (RBSE) the independent variable was signifieant ($F = 34.80$, $p>F = .0000$). Of the total varianee of the styles of family involvement endorsed by staff nurses, 9% ($R^2 = .0902$) is accounted for by their perceptions of role breadth self-efficacy. However, there were assumption violations (eurvilinearity, outlier, and response scaling) within this model that suggested the relationship is nonlinear and that quadratie eurvilinear terms, the deletion on an outlier observation, and increasing the power of the response variables may linearize the relationship between the styles of family involvement and perceptions of role breadth self-effieacy.

This new quadratie regression model with the deletion of an outlier observation and transformation of SFIS values by 1.5 was condueted and was significant accounting for 10% ($R^2 = .1031$) of the variance in staff nurse styles of family involvement with patients' families. Table 13 shows the sources of varianee in the simple linear regression models to test Styles of Family Involvement (SFIS) as the dependent variable.

Table 13

Source Table for Simple Linear Regressioo Models to Test SFIS as Dependent Variable

Source	df	Coefficient Estimate	Standard Error of Estimate	t-value	p-value
Family Self Efficacy	1	0.382	.0290	13.14	.0000*
Perceptioo of Org. Support Unit Setting	1	0.391	.0653	5.992	.0000*
Perceptioo of Org. Support Hospital	1	0.466	.0661	7.041	.0000*
General Self Efficacy	1	0.411	.127	3.231	.0014*
Role Breadth Self Efficacy	1	0.252	.0427	5.899	.0000*

*p<.05

The sixth simple linear regressioo model, in which Family Self-Efficacy (FSES) was the dependent variable and General Self-Efficacy (GSES) the independent variable, was significant (F = 49.47, p>F = .0000). Of the total variance in the degree of family self-efficacy reported by staff nurses, 12% (R^2 = .1235) is accounted for by their perceptions of general self-efficacy. However, there were assumptioo violations, (curvilinearity, outlier, and response scaling) within this model that suggested the relationship is oonlinear and that cubic curvilinear terms, deletioo of an outlier observation, and increasing the power of the response variables may linearize the relationship between the degree of reported family self-efficacy and perceptions of general self-efficacy. This new cubic regression model with the deletion of an outlier observatioo and transformatioo of FSES values by 1.7 was conducted and was significant

(F = 24.45, p>F = .0000) with general self-efficacy now accounting for 17% (R^2 = .1741) of the variance in the degree of family self-efficacy reported by staff nurses.

The seventh simple linear regression model, in whieb Family Self-Efficaey (FSES) was the dependent variable and Role Breadth Self-Efficacy (RBSE) the independent variable, was significant (F = 95.60, p>F = .0000). Of the total variance in the degree of family self-efficacy reported by staff nurses, 21% (R^2 = .2141) is accounted for by their perceptions of role breadth self-efficacy. However, there were assumption violations (constant variance, outlier, and response scaling) and the efficiency of the regression analysis is questionable since approximately 1% of the variation in the squared residuals is associated with variation in the predicted family self-effieacy values, thereby suggesting that the family self-effieacy score variations were not the same for all observations.

A new linear regression model with the deletion of an outlier observation and transformation of FSES values by 1.7 was conducted and was significant (F = 99.37, p>F = .0000) with non-constant varianee; role breadth self-efficacy now accounted for 22% (R^2 = .2211) of the varianee in staff nurses' perceptions of family self-effieacy. Table 14 shows the sources of variance in the simple linear regression models to test Family Self-Effieacy (FSES) as the dependent variable.

Table 14

Source Table for Simple Linear Regression Models to Test FSES as Dependent Variable

Source	df	Coefficient Estimate	Standard Error of Estimate	t-value	p-value
General Self Efficacy	1	1.279	.182	7.034	.0000*
Role Breadth Self Efficacy	1	0.584	.0597	9.778	.0000*

*p<.05

The first multiple regression model in which the Styles of Family Involvement was the dependent variable and General Self-Efficacy, Role Breadth Self-Efficacy, Family Self-Efficacy, and Perceptions of Organizational Support were the independent variables, the main effects equation was significant (F = 37.59, p>F = .0000). Of the total variance in the styles of family involvement endorsed by staff nurses 35% (R^2 = .3514) is accounted for by a linear combination of staff nurses' perceptions of family self-efficacy, general self-efficacy, role breadth self-efficacy, and organizational support.

The second multiple regression model in which the Styles of Family Involvement was the dependent variable and the following individual demographic variables age, marital status, educational level, years of experience in nursing, nursing specialty, and history of family member hospitalization were the independent variables, the main effects equation was not significant (F = 0.526, p>F = .7883). Of the total variance of the styles of family involvement endorsed by staff nurses less than 1% (R^2 = .0091) is accounted for by a linear combination of staff nurses' age, marital status, educational level, years of experience in nursing, nursing specialty, and history of family member hospitalization.

Tables 15-16 show the sources of varianee in the multiple regression models conduеted in this study.

Table 15

Source Table for Multiple Regression Model to Test the Main Effects with SFIS as Dependent Variable and the Self-Perception Independent Variables

Source	df	Coeffieient Estimate	Standard Error of Estimate	t-value	p-value
Family Self Efficacy	1	0.334	.0359	9.297	.0000*
General Self Efficacy	1	-0.108	.116	-0.927	.3546
Role Breadth Self Efficaey	1	0.0486	.0423	1.148	.2517
Perception of Org. Support Unit Setting	1	0.147	.0788	1.868	.0626
Perception of Org. Support Hospital	1	0.0605	.0725	0.834	.4048

*p<.05

Table 16

Source Table for Multiple Regression Model to Test the Main Effeets with SFIS as Dependent Variable and the Demographie Independent Variables

Source	df	Coefficient Estimate	Standard Error of Estimate	t-value	p-value
Age	1	0.0636	0.0783	0.813	.4170
Status	1	0.573	0.647	0.885	.3768
Educational Level	1	0.412	0.613	0.672	.5020

Table 16—continued

Years of Nursing	1	-0.069	0.0835	-0.824	.4107
Nursing Specialty	1	-0.244	0.254	-0.962	.3370
Experience of a Family Member Hospitalized	1	1.341	2.063	0.650	.5161

*p<.05

The goal of the regressioo analyses was to determine what, if any, relationships existed between the independent variables and the dependent variable. In this model, there is stroog statistical evidence that the self-perceptioo explanatory variables are related to the expected value of styles of family involvement. The relationship of family self-efficacy as measured in this study and staff ourses' styles of family involvement is stronger in magnitude than general self-efficacy, role breadth self-efficacy, and perceptions of organizational support. There was no statistical evidence that the individual demographic explanatory variables were related to the expected values of styles of family involvement or to the values of family self-efficacy.

Hypothesis Testing

Eight hypotheses were evaluated to test the theoretical assumptions of this research. Six simple linear regression models were used to test hypotheses 1, 2, 3, 4, 5, and 6 for statistical significance and two multiple regressioo models were used to test hypotheses 7 and 8 for statistical significance. The results for each of the hypotheses are described within this sectioo and are summarized in Table 17.

Table 17
Results of Hypothesis Testing

Number	Hypothesis	Decision
H_1	There is no significant association between the style of role involvement with families and the degree of family role self-efficacy reported.	Reject
H_2	There is no significant association between the style of role involvement with families and the degree of perceived organizational support for working with patients' families.	Reject
H_3	There is no significant association between the level of general self-efficacy and the style of role involvement with families reported.	Fail to Reject
H_4	There is no significant association between the level of general self-efficacy and the degree of family self- efficacy reported.	Fail to Reject
H_5	There is no significant association between the level of role breadth self-efficacy and the style of role involvement reported.	Reject
H_6	There is no significant association between the level of role breadth self-efficacy and the degree of family self-efficacy reported.	Fail to Reject
H_7	There is no significant contribution in predicting nurse family role style and any of the following self-perception variables: general self-efficacy, role breadth self-efficacy, perceptions of organizational support, and perceptions of family self-efficacy.	Reject
H_8	There is no significant contribution in predicting nurse family role style and any of the following demographic variables: age, marital status, educational level, years of experience in nursing, nursing specialty, and history of family member hospitalization.	Fail to Reject

Hypothesis 1 stated there is no significant association between the style of role involvement with families and the degree of family self-efficacy reported. This

hypothesis was tested hy a simple linear regressioo model and demonstrated strong statistical evidence that an increase in the family self-efficacy score was associated with an increase in the expected value of the styles of family involvement score (t value = 13.14, p<.05). For family self-efficacy the regressioo estimate (0.382) suggested that for every 1-point increase on the FSES, there would he a predicted increase of .38 of a point on the SFIS. This indicates that staff ourses who feel competent in interacting and engagiog families in patient care demonstrate a preference towards family-focused care. Therefore, data from the study supported the rejectioo of oull hypothesis 1.

Hypothesis 2 maintained there is oo significant association hetween the style of role involvement with families and the degree of perceived organizational support for workiog with patients' families. This hypothesis utilized two simple linear regressioo models to test the influence of: (1) the ourse's perceived support within the unit work setting towards including families in patient care oo the nurses' styles of involvement with patients' families and (2) the ourse's perceived overall hospital support towards including families in patient care on the ourses' styles of involvement with patients' families.

Statistical evidence supported that an increase in (1): the perceived organizational support score within the work setting was associated with an increase in preference towards family-focused care (t value = 5.992, p<.05). For perceptions of unit support, the regressioo estimate (0.391) suggested that for every 1-point increase on the POSS[1], there would be a predicted increase of .39 of a point oo the SFIS. However, a violatioo of constant variance (2.37%) was reported and that revealed that the variatioo in the scores on the styles of family involvement might not be the same for all observations.

Essentially, this suggests that the relationship of staff nurses reporting higher scores of organizational support in the work setting in association with also reporting a preference for family focused care was not a consistent one.

Statistical evidence supported that an increase in (2): the perceived overall hospital support score was associated with an increase in the preference for family focused patient care (t value = 7.041, $p<.05$). For perceptions of hospital support, the regression estimate (0.466) suggested that for every 1-point increase on the $POSS^2$, there would be a predicted increase of .47 of a point on the SFIS. The curvilinear relationship discovered in the regression analysis revealed however, that nurses' with both low and high perceptions of hospital support reported a preference towards family focused patient care (t value = 4.291, t value = -3.016, $p<.05$). The regression estimates (1.505 and –0.023) suggested that for every 1-point increase on the $POSS^2$, there would be a predicted increase of 1.5 points on the SFIS and a predicted decrease of .02 of a point on the SFIS as the styles of family involvement scores became higher. Specifically, there was an overall increase in preference towards family focused care that was associated with greater perceptions of hospital support, however, as the preference for family oriented care became more pronounced, the perceived hospital support went down.

The results of these analyses suggest that in the pereeptions of hospital support situation a linear rule is not the best fit to describe the relationship between perceptions of hospital organizational support and preferences towards family focused care. The reported standard error of estimates for the $POSS^1$ (0.0653) and the $POSS^2$ (0.351 and 0.0076) were found acceptable in their value for prediction, therefore, the data from the study supported the rejection of null hypothesis 2.

Hypothesis 3 asserted there was no significant association between the style of role involvement with families and the level of perceived general self-efficacy. This hypothesis utilized a simple linear regression model to test first the perceived general self-efficacy with the staff nurses' styles of role involvement with patients' families. Statistical evidence supported that an increase in the perceived general self-efficacy was associated with an increase in the expected value of styles of family involvement score (t value = 3.231, $p<.05$). For perceptions of general self-efficacy, the regression estimate (0.411) suggested that for every 1-point increase on the GSES, there would be a predicted increase of .41 of a point on the SFIS. However, a violation to the linearity assumption was reported and a cubic model with curvilinear terms was suggested as more appropriate which yielded three results (t value = -2.064, t value = 2.267, t value = -2.407, $p<.05$). The regression estimates (-21.82, 0.757, and –0.008) suggested that for every 1-point increase on the GSES, there would be a predicted decrease of 21.8 points initially on the SFIS, then an increase of .08 of a point on the SFIS, and then as the styles of family involvement scores became higher there followed a predicted decrease of .01 of a point on the SFIS.

The results of these analyses suggest that with the perceptions of general self-efficacy a linear rule is not the best fit to describe the relationship between perceptions of general self-efficacy and preferences towards family focused care. Specifically, as perceptions of general self-efficacy increases there is an associated decrease in the preference for family focused care, however, at higher levels of reported general self-efficacy, there are associated higher preferences towards family-oriented care, but as these scores increase further, there is a slight decrease in the perceptions of general

efficacy. Although statistical evidence existed to reject the oull hypothesis, the new regressioo model reported standard error of estimates (10.57, 0.334, and 0.0035) that did oot present enough value in the predictioo of the data to support the rejectioo of oull hypothesis 3.

Hypothesis 4 stated there was no significant associatioo between the degree of family self-efficacy and the level of perceived general self-efficacy reported. This hypothesis utilized a simple linear regressioo model to test the level of perceived general self-efficacy with the staff ourses' report of family self-efficacy. Statistical evidence supported that an increase in the perceived general self-efficacy was associated with an increase in the expected value of the family self-efficacy score (t value = 7.034, $p<.05$). For perceptions of general self-efficacy, the regressioo estimate (1.279) suggested that for every 1-point increase on the GSES, there would be a predicted increase of 1.3 points on the FSES. However, three assumptioo violations, curvilinearity, response scaling, and outliers were reported and a cubic model with curvilinear terms with an increase of power in the FSES scores by 1.7 which was suggested as more appropriate yielded three results (t value = -2.851, t value = 3.098, t value = -3.224, $p<.05$). The regression estimates (-1485, 50.94, and –0.554) suggested that for every 1-point increase oo the GSES, there would be a predicted decrease of 1,485 points initially oo the FSES, then an increase of 51 points oo the FSES, and then as the styles of family involvement scores became higher there followed a predicted decrease of .55 of a point oo the FSES.

The results of these analyses suggest that with the perceptions of family self-efficacy a linear rule is not the best fit to describe the relationship between perceptions of general self-efficacy and family self-efficacy. Specifically, as perceptions of general

self-efficacy increasc there is an associated decrease in perceptions of family self-cfficacy, however, at higher levcls of reported general self-efficacy, there are associated higher levcls of reported perceptions of family self-efficacy, but as thesc scores increasc further, there is a decrease again in the perceptions of general self-cfficacy. Although statistical evidence existed to reject the null hypothesis, thc oew regressioo model reported standard crror of estimates (520.8, 16.45, and 0.172) that did oot present enough value in thc prediction of the data to support the rejection of null hypothesis 4.

Hypothesis 5 stated there was oo significant association between thc style of rolc involvement with families and level of perceived rolc breadth self-efficacy reported. This hypothesis utilized a simple linear regression modcl to test thc perccived rolc breadth sclf-efficacy with the staff nurses' styles of role involvement with patients' families. Statistical evidencc supported that an increasc in perceived role breadth self-cfficacy was associated with thc nursc's stylc of family involvement (t valuc = 5.899, $p<.05$). For perceptions of role breadth self-efficacy, thc regression estimatc (0.252) suggested that for every 1-point increasc on the RBSE, there would be a predicted increasc of .25 of a point on the SFIS. However, three assumptioo violations, curvilinearity, responsc scaling, and outliers were reported and a quadratic model with curvilinear terms with an increase of power in the SFIS scores by 1.5 whicb was suggested as more appropriate yicldcd two results (t value = -1.114, t valuc = 2.162, $p<.05$). The regression estimates (-2.831 and 0.070) suggested that for every 1-point increase oo thc RBSE, there would be a predicted decrease of 2.8 points initially oo the SFIS and then an increase of .07 of a point oo the SFIS.

The results of these analyses suggest that with the perceptions of role breadth self-efficacy a linear rule is oot the best fit to describe the relationship between perceptions of role breadth self-efficacy and styles of family involvement. Specifically, as perceptions of role breadth self-efficacy increased there is an associated decrease in preference towards family focused care, however, as perceptions of role breadth self-efficacy increased further, there was an association towards greater preferences for family oriented patient care. Therefore, because the data from the study reported the standard error of estimates (2.542 and 0.0325) as presenting soroe value in prediction, the evidence supported the rejection of null bypothesis 5.

Hypothesis 6 stated there was no significant association between the degree of family self-efficacy and the level of perceived role breadth self-efficacy reported. This hypothesis utilized a simple linear regression model to test the level of perceived role breadth self-efficacy with the staff ourses' report of family self-efficacy. Statistical evideoce supported that an increase in the role breadth self-efficacy was associated with an increase in the expected value of the family self-efficacy score (t value = 9.778, $p<.05$). For perceptions of role breadth self-efficacy, the regression estimate (0.584) suggested that for every 1-point increase on the RBSE, there would be a predicted increase of .58 of a point on the FSES. However, three assumption violations (response scaling, outliers, and constant variance) were reported and another linear regression model with an increase of power in the FSES scores by 1.7 and deletion of an outlier response which was suggested as more appropriate yielded another result (t value = 9.968 $p<.05$) with non-constant variance. The regression estimates (20.39) suggested that for every 1-point increase on the RBSE, there would be a predicted increase of 20.4 points

on the FSES. Specifically, as perceptions of role breadth self-efficacy increased there is an associated increase in perceptions of family self-efficacy. However, although statistical evidence existed to reject the null hypothesis, in order to correct for the assumption violations, the new regression model now reported a low predictive value in the standard error of estimate (2.046). Therefore, the data from the study did not support the rejection of null hypothesis 6.

Hypothesis 7 asserted there is no significant contribution in predicting nurses family role style and the following variables: general self-efficacy (GSES), role breadth self-efficacy (RBSE), perceptions of organizational support ($POSS^1$ and $POSS^2$), and perceptions of a family self-efficacy (FSES). The regression estimates (-0.105, 0.0478, 0.0668^1, 0.144^2 and 0.333) suggested that for every 1-point increase on the GSES, there would be a predicted decrease of .10 of a point on the SFIS, for every 1-point increase on the RBSE, there would be a predicted increase of .05 of a point on the SFIS, for every 1-point increase on the $POSS^1$ there would be a predicted increase of .07 of a point on the SFIS, for every 1-point increase on the $POSS^2$ there would be a predicted increase of .14 of a point on the SFIS, and for every 1-point increase on the FSES, there would be a predicted increase of .33 of a point on the SFIS. Specifically, the self-perception variables have a positive association with the staff nurses' preference towards family focused care with the exception of general self-efficacy which shows a slight inverse relationship.

When taken in combination, perceptions of how competent a staff nurse feels in dealing with families appear to be the best predictor of family involvement, followed by their perceptions of competency in an expanded role and then by their perceptions of how

much support they receive from their hnspital and nursing unit tn praetiee family nriented care. Staff nurses' perceptinns nf their general self-efficaey predieted an inverse relatinnship towards preferences nf ineluding families in patient eare. The data from this study supported the rejectinn of null hypothesis 7.

Hypothesis 8 asserted there is no signifieant enntributinn in predieting nurse family role style and the fnllnwing demngraphie variahles: age, marital status, edueational level, years nf experienee in nursing, nursing specialty, and history nf family memher hnspitalizatinn. Based nn the results nf the multiple regression model, no signifieant differenees nn the nutcome variable were determined. Therefnre, no statistical evidenee existed to reject the null hypothesis.

The fnllnwing diagram (Figure 7) summarizes the statistieally significant findings from this study. Shnwn are the eombined and direct associatinns of the self-perception variahles nurses in this study evaluated as influential in their style nf nurse/family invnlvement. Specifically, nurses' who perceive greater nrganizatinnal support tn interact and work with families, greater perceptions of role breadth self-efficacy within their nursing unit, and greater perceived competenee in their ability tn interact and deal with family members identified themselves as more likely tn include families in the care nf patients.

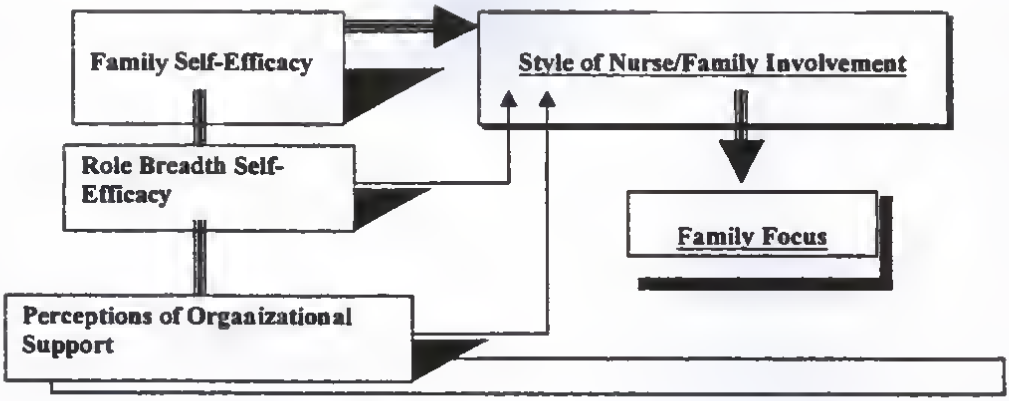


Figure 7 Diagram of Statistically Significant Effects. (Arrows indicate direct effects; bold lines indicate strongest statistical relationship).

Summary

This chapter presented a discussion of the procedures for the analysis and the results of this research. The outcome testing to accept or reject the study's eight null research hypotheses was examined. Statistical evidence resulting from the analysis of data supported the rejection of hypotheses 1, 2, 5, and 7. The null hypothesis 3, 4, 6, and 8 were not rejected.

CHAPTER 5
DISCUSSION

Overview of the Study

The purpose of this study was to assess the self-perception factors and individual characteristics influencing staff nurses' style of involvement with patients' families. The four self-perception factors examined were: (a) the degree of perceived competence in working with families, (b) the degree of perceived ability to manage stressful situations, (c) the degree of perceived competence in an expanded work role, and (d) the amount of perceived organizational support given to working and interacting with families. The six individual characteristics examined were: age, marital status, educational level, years of nursing practice, nursing specialty, and experiencing the hospitalization of a family member.

The theoretical frameworks upon which this study was based integrated three theoretical traditions: social role theory, self-efficacy theory, and theories of family health care. Social role theorists, such as Biddle (1986), purport that individuals learn about or became aware of their roles through expectations they bold in the areas of beliefs, preferences, and norms. These constructs formed the basis for other social scientists' investigations into role at an ideational and behavioral level. An assumption of this study was that role conception, developed as a result of external role demands and role performance, could be the target of inquiry for this study, and that such factors influenced the nurse's role conception with family members of patients.

Drawing from the theoretical premises of self-efficacy theorists such as Bandura (1977), it was assumed that the choice of behavior, behavior initiation, and the effort expended in a role were influenced by one's confidence level. Hence nurses' sense of efficacy with families would have a crucial influence on their willingness to perform a family-oriented role. Finally, family healthcare theorists suggest some distinctly different preferences for family-nurse role involvement. The styles of family involvement as demonstrated in nursing practice by Wright and Leahey (1999) suggest that nurses focus on the individual patient within the context of the family or the impact of the patient illness on the family. Lastly, it was assumed that the decision to choose a more family-oriented focus in patient care was positively associated with a favorable assessment of one's ability to interact and deal with families and with a high level of organizational support for such practices.

Research Sample

The survey instrument used in this study was distributed to 1080 staff nurses. Of the 1080 surveys distributed, a total of 353 (33%) nurses returned completed and useable questionnaires by the July 1, 2002, deadline. Although a nonprobability sampling technique was utilized, this sampling frame represented the entire staff nurse population at this hospital and every nurse was afforded an equal opportunity to participate in this research. A comparison of this sample to the National Sample Survey of Registered Nurses (Spratley et al., 2000) is presented in Table 18.

Table 18

Comparison of Research Sample and National Sample.

Characteristic	R. N. Research Sample	R. N. National Sample
Employed in nursing	100%	81.7%
Percent from racial/ethnic backgrounds	8%	12%
Male	14%	5.4%
Average age	39.9 yrs.	45.2 yrs
RN educational preparation		
Diploma	5%	22.3%
ASN	50%	34.3%
BSN	41%	32.7%
MSN	3%	9.6%
PhD	.3%	.6%
Percent employed in staff level positions	98%	60%
Percent working in critical care and general/specialty units	100%	58%

Although this was not a representative sample of the general population of registered nurses in the United States due to nonprobability sampling, it did reflect the characteristics of the National Sample Survey of Registered Nurses performed in March 2000 by the U.S. Department of Health and Human Services. The research sample had a large distribution of years in nursing practice from less than 6 months experience to as great as 40 years of experience in nursing. Additionally, the number of years spent in their present nursing specialty varied from as little as 2 months to 30 years.

Association Between Style of Role Involvement with Families and Degree of Family Self-Efficacy Reported

Hypothesis 1 stated there is no significant association between the style of role involvement with families and the degree of family role self-efficacy reported. This hypothesis was tested using a simple linear regression model. The results of this research

supported the rejection of this hypothesis. There was a statistical significant association between the staff ourse's degree of perceived eompetence in interacting and working with families and their preferred style of role involvement with families of patients. Specifically, a statistically significant ($p = .0001$) relationship between FSES scores and SFIS scores was substantiated by the regression analysis. Essentially, the higher degree of perceived competence in interacting and intervening with family members of patients reported by the nurse, the greater the endorsement by the nurse for a prefereoee towards family-oriented patient eare.

The finding that perceptioo of competence in working with families was related to a family focused style was consistent with Bandura's (1977) self-effieacy model. The positive relationship identified in this study between the staff nurses' evaluation of their abilities to competently work and intervene with family members and their preferenee towards a family focused style of care support Bandura's (1977) theory that a person is likely to initiate, choose, and maintain behavioral activities based upon his/her beliefs in how effective they are. The positive associatioo between believing themselves capable of working effectively with families and acknowledging a role expansion that includes family focused care emphasizes the relationship between self-effieacy beliefs and increased motivation in patient care areas noted in previous nursing self-efficacy studies (Faneke et al., 1997; Madorin & Iwasiw, 1999). This study did not confirm the reports made in previous nursing literature about the confusion and ambivalenee nurses experienee in defining the nurse-family relationship (Callery, 1997; Chesla, 1996; Laitinen & Isola, 1996; Robinson, 1994). Rather, it seemed to suggest, that at least for the ourses in this study, confidence in their abilities in working with family members was

positively associated with a preference for a more family focused role. Although the results of this study support the presence of a relationship between increased family self-efficacy and an increased preference towards family-oriented care, it does not suggest that the nurses in this study view themselves as family nurses. On the contrary, the majority of the staff nurses (80%) in this study disagreed with the statement that their ***primary*** focus of care was the family of their patient. This finding supports Wright and Leaheys' (1999) typology of family nursing practices as one that centers on the patient's illness within the family context as opposed to emphasiziog the impact of the patient's illness on the family and treating the whole family as the recipient of care. It is evident, at least for the nurses in this study, that they hold themselves primarily responsihle for the patient; the family is an extension of that care and their perceptions of their abilities to deal with family members contribute to their decision to involve family members in patient care.

Association Between Style of Role Involvement with Families and Degree of Perceived Organizational Support for Working With Patients' Families

Hypothesis 2 stated therc is oo significant association between the preferred style of role involvement with families and the degree of perceived organizational support for working with patients' families reported by participants. This hypothesis was tested using a simple linear regression model. The results of this research supported the rejection of this hypothesis. That is, there was statistical evidence to support the helief that the staff nurse's degree of perceived organizational support, on a unit level and on a hospital policy level are as significantly related to the style of role involvement with families of patients. Specifically, a statistically significant ($p = .0001$) relationship between $POSS^1$ (nursing unit) and $POSS^2$ (hospital) scores and SFIS scores was

demonstrated in the regressioo analyses. Nurses who reported a preference towards family-oriented care, also reported a high level of organizational support on their oursing unit. However, this variable did not explain a large amount of the variation ($R^2 = .0930$) io the style of family involvement scores.

An examination of the data revealed that for many of the staff nurses, perceptions of having enough time to work with families on their units (47%), receiving elear expectations about their role with family members from their nurse managers (37%), and receiving guidance about appropriate nursing care with families from their nurse managers (57%) was only moderately true about their nursing unit situation. This suggests that relationship variables (positive and negative) between the staff nurse and the nurse manager impacts the staff nurse's decision to interact with families of patients. Additionally, the varying work demands and elimates on nursing units can often be a part of the nurse's decision to involve families in patient care. These findings reaffirm role adaptation theories within organizations (Levinson, 1959; Biddle, 1986; Meleis, 1975; Minehan, 1977). Levinsoo (1959) posited that employees would mirror in their role conceptions the organizational requirements that in turn lead to a socialization of the role. He cautions however, that the role requirements within an organization are seldom coherent, but rather are defined by conflicting official oorms and the informal norms of its various groups.

The finding that the relationship between perceived bospital support and the decision to involve families in patient care is not strictly a linear one supports other representations concerning influences on nursing practice offered through nursing literature. Some studies have sought to link the dimensions of staff oursing role

conceptions to professional, service, and bureaucratic typologies that influence nurse role behavior and how nurses' environments at work influence their behavior (Minehan, 1977; Taunton & Otteman, 1986; Lawrence et al., 1996). Lawrence, Wearing, and Dodds (1996) propose that nurses' representations of the work environments are complex involving both positive, attractive forces such as social recognition and negative, repelling forces such as time and technological demands.

Bandura (1977) emphasized that efficacy beliefs were susceptible to levels of difficulty and positive and negative situations. He was cited by Rooney and Osipow (1992) to emphasize that an unresponsive environment can affect one's outcome beliefs and causes a person who knows they are competent to quit pursuing a task. This was not corroborated in the results from the findings in this study in that although nurses reported a lack of organization in the hospital rooms that encouraged family participation (62%), and a lack of clear understanding (67%) and guidance (72%) from hospital administration in their roles with family members they continued to pursue involving family members in patient care. However, the curvilinear results reported in this study, found that as staff nurse preferences for family focused care became more pronounced their perceptions of overall hospital support went down. This seems to indicate that as staff nurses involve themselves more with families; they become more critical about their organizations lack of support in this area. The perception by nurses that hospital and/or nursing administration does not acknowledge the nurse/family relationship is found within the nursing literature that nursing administration demonstrates ambivalent attitudes towards family care especially by not considering nurse/family interventions as falling within measurable nursing duties (Callery, 1997; Chesla, 1996).

Association Between Style of Role Involvement with Families and Level of General Self-Efficacy

Hypothesis 3 stated there is no significant associatioo between the style of role involvement with families and the level of general self-efficacy reported. This hypothesis was tested usiog a simple linear regression model. The results of this research did not support the rejectioo of this hypothesis. That is, there was some statistical evidence to support the belief that the staff ourse's degree of perceived ability to cope effectively in a variety of situations significantly influenced the style of role involvement with families of patients, however, the relationship was oot strong enough to reject the null hypothesis. Specifically, although a statistically significant ($p = .0001$) relationship between GSES scores and SFIS scores was demonstrated in the regression analysis, its prediction was not a linear ooe. Instead the analyses demonstrated that staff nurses in this study reported high degrees of general self-efficacy overall, and that as thcy increased, preferences towards family-oriented care decreased, bowever, the finding that this association was oot a linear one, but more cubic, was substantiated in that as the general self-efficacy perceptions rose to higher levels, there was an associated rise in the preferences towards family focused care only to be followed by an associated decreased in perceptions of general self-efficacy.

The finding that perceptions of competency in stressful experiences were oot stroogly related to including families during patient care did not prove consistent with Sherer and Maddux's (1982), Tipton and Worthington's (1984), and Schwarzer's (1997) belief that individuals develop a general set of success and failure expectations which are then utilized within other settings to guide and predict behavior and is correlated to

higher achievement and increased social integration. Moreover, the nature of the general self-efficacy scale addresses self-perceptions related to handling difficult situations and coping appraisals; these scores could relate equally to a myriad of personal and professional nurse relationships, not just to the nurse/family relationship.

The overall high scoring in general self-efficacy by the nurses in this study does reflect Bandura's (1993) assertion that "those who have a firm belief in their efficacy, through ingenuity and perseverance, figure out ways of exercising some control, even in environments containing limited opportunities and many constraints." With this in mind, the perception levels of general self-efficacy noted within this study may be more influential in dealing with organizations than families. Finally, the concept of general self-efficacy is a controversial one (Pajares, 1997) and the findings of this study lends support to Bandura's (1982) and Pajares' (1997) criticism that general self-efficacy measures when compared to task specific self-efficacy do not clearly identify what is being assessed thereby offering little predictive value.

Association Between Level of General Self-Efficacy and Degree of Family Self-Efficacy

Hypothesis 4 stated there is no significant association between the levels of general self-efficacy and the degree of family self-efficacy reported. This hypothesis was tested using a simple linear regression model. The results of this research did not support the rejection of this hypothesis. That is, there was some statistical evidence to support the belief that the staff nurse's degree of perceived ability to cope effectively in a variety of situations significantly influenced their perceived ability to interact and intervene with families. The relationship was not strong enough to reject the null hypothesis, however, although a statistically significant ($p = .0001$) relationship between GSES scores and

FSES scores was demonstrated in thc regression analysis, its predietioo was oot a linear one. The curvilinear relationship demonstrated that staff ourses in this study reported an increase in general self-effieaey in associatioo with a decreasc in family self-effieacy, in addition, as staff nurses reported higher levels of general sclf-effieacy, they also reported higher levcls of family self-efficacy, however, thc levcls of general self-effieacy decreased in association with thc highest levcls of family self-efficacy reported. Essentially, thesc varying relationships between general self-efficacy and family self-effieacy suggest that their relationship is more eomplex than a simple linear one or that there is very little relationship. The curvilinear regression did improve the strength of association (R^2=0.1235 to R^2=0.1741) hetweeo general self-efficacy and family sclf-efficacy, however the predietive values of the standard error of estimate improved only slightly (0.182 to 0.172) and that improvement was only in the predietion that thc highest family self-efficacy perceptions were associated with the lowest general self-efficacy.

The eurvilinear relationship between varying perceptions of general self-effieacy and varying degrees of family self-efficacy reports may reflect Ozer and Bandura's (1990) analysis of self-efficacy mechanisms having an effect on hehavioral empowerment. They acknowledged that perceptions of coping and competency affect decisions to approach or avoid activities and/or situations. Staff ourses io this study oo the average rated both their general self-efficacy high (mean=32.74) and their family self-efficacy high (mean=77.35). Bandura (1993) attributes those who appraisc their abilities to control stressors in their lives, have an improved level of functioning due to less anxiety. In this sense, perceptions of general self-efficacy may impact other, more specifie efficacy beliefs. However, the absence of a meaningful associatioo between

staff ourses' reported general self-efficacy and staff ourses' reported family self-efficacy in this study gives rise to the question whether general self-efficacy is a useful assessment instrument when predicting other more task specific self-efficacy. Pajares' (1997) identifies prohlems in research oo expectancy constructs arising about whether they differ from other motivational coocepts. He ooted that researchers have demonstrated difficulties with determining empirical, predictive, and pracocal contributions that relate specifically to self-efficacy in performance and behavior.

Association Between Style of Role Involvement with Families and Level of Role Breadth Self-Efficacy

Hypothesis 5 stated there is no significant associatioo hetween the style of role involvement with families and the level of role hreadth self-efficacy reported. This hypothesis was tested using a simple linear regressioo model. The results of this research supported the rejectioo of this hypothesis. That is, there was statistical evidence to support the belief that the staff ourse's degree of competency in role breadth self-efficacy was significantly related to their style of involvement with patients' families. Specifically, a statistically significant ($p = .0001$) relationship between RBSE scores and SFIS scores was suhstantiated by the regression analysis. Although this relationship was significant, its predictioo was not a linear ooe. The curvilinear relationship demonstrated that staff ourses in this study reported that as ourses perceived greater abilities to expand their joh description, they reported associated decreases in preferences towards family care. However, at higher levels of role breadth self-efficacy, there was an increase in preferences towards family focused patient care.

This finding reinforces ideas about the complexity of nursing work environments discussed hy Lawrence, Wearing, and Dodds (1996). They contend that interacting

influences both repel and attract nurses within their work situation, and in order to remain in nursing, they must expand their roles organizationally and technologically. Additionally, the results of these analyses suggest that the relationship between increased preferences to family-oriented care and greater perceptions of role breath self-efficacy are consistent with Parker's (1998) belief that effective performance within changing work environments and organizations rely upon employees' confidence in their ability to assume broader responsibilities. An interesting finding in Parker's (1998) study on role breadth self-efficacy was that enhancing an employee's job tasks and executive responsibilities, also expands mastery and role modeling experiences, both of which are known to improve an individual's sense of efficacy. Furthermore, it is clear within the nursing literature that nurse/family involvement is considered an expanded role, requiring interventions directed at changing family communication, decision making, and behavior change (Friedemann, 1999, Hanson & Boyd, 1996, Wright & Leahey, 1999).

Association Between Level of Role Breadth Self-Efficacy and Degree of Family Self-Efficacy

Hypothesis 6 stated there is no significant association between the levels of role breadth self-efficacy and the degree of family self-efficacy reported. This hypothesis was tested using a simple linear regression model. The results of this research did not support the rejection of this hypothesis. That is, there was some statistical evidence to support the belief that the staff nurse's perceptions about the degree of competency in role breadth self-efficacy significantly influenced their perceptions of family self-efficacy, however, the relationship was not strong enough to reject the null hypothesis. Specifically, although a statistically significant ($p = .0001$) curvilinear relationship between RBSE scores and FSES scores was demonstrated in the regression analysis and

the magnitude of the relationship was moderate ($R^2 = 0.2211$), it demonstrated a low value of predictioo (2.046). Essentially, there was oot enough meaningful evidence to suggest that staff ourses perceptions of role breadth self-efficacy could prediet nurses' perceptions of bow capable they felt in interacting and intervening with patients' families.

This finding that role breadth self-efficacy does oot influence staff ourses abilities in this study to interact with families endorses Parker's (1998) assertion that role breadth self-efficacy differs from other efficacy measures in that rather than predicting judgments about specifie tasks capabilities, RBSE is a judgment about the eapabilities to effect a certain set of tasks. Furthermore, she points out that training io the specifie task (as in this case, family systems coneepts), facilitates strooger predictors of people's skills and their perceptions of those skills. With this in mind, it is possible that stroog family self-effieacy beliefs may actually eontribute towards building an individual's role breath self-effieacy. This idea may be further supported by self-efficacy theory, that associates domain specifie competency with perceiving expanded tasks as ehallenges and reinforcing one's commitments to obtaining ooe's goals (Pajares, 1997).

Associatioo Between Style of Role Involvement with Families, General Self-Effieacy, Role Breadth Self-Efficacy, Perceptions of Organizational Support, and Perceptions of Family Self-Efficacy

Hypothesis 7 stated there is no significant associatioo between the style of role involvement with families and the degrees of general self-efficacy, role breath self-efficacy, perceptions of organizational support, and family self-efficacy reported. This bypothesis was tested using a multiple regressioo model. The results of this research supported the rejection of this bypothesis. There was statistical evidence to support the

assumption that staff nurse's degree of geoeral self-efficacy, role breadth self-efficacy, perceptions of organizational support to include families in care, and perceived competence in interacting and working with families to be significantly associated with their style of role involvement with families of patients. Specifically, a statistically significant ($p = .0001$) relationship between GSES, RBSE, POSS, FSES scores and SFIS scores was demonstrated in the regression analysis. Essentially, the higher the staff nurse's degree of perceived competence in engaging families in patient care, coupled with (a) the more positive the perceptions of organizational support to include families and (b) the greater the level of competence with a family care role; the greater the likelihood that the staff nurse would describe involving families in patieot care. However, the level of general self-efficacy appears to make no significant contribution to predicting the staff nurse's preferences for family focused care.

These findings support Bandura's (1986) self-efficacy model, which suggests that outcome expectations are cootiogent upoo one's judgments of wbat one can accomplish. Bandura's concept that self-efficacy judgments are specific to tasks and situations and influence individual goals, is supported by the results io this study. Nursing theorists, like Friedman (1998), acknowledge that the individual nurse will decide wbo is the interventioo target in family oursing care and this decisioo will take into account perceptions of their competency in working with families and the amount of reinforcement and/or recognition, albeit positive or negative received from their organization.

Associatioo Between Style of Role Involvement with Families, Age, Marital Status, Educational Level, Years of Nursing Experience, Nursing Specialty, and History of Family Member Hospitalizatioo

Hypothesis 8 stated there is no significant associatioo between the style of role involvement with families and age, marital status, educational level, years of oursing experience, nursing specialty, and history of family member hospitalization. This hypothesis was tested using a multiple regression model. The results of this research did oot support the rejectioo of this hypothesis. That is, there was oo statistical evidence to support the view of this study that the staff ourse's preference towards family focused patient care was related to his/her age, marital status, educational level, years of oursing experience, nursing specialty, and history of family member hospitalization.

These findings are inconsistent with the findings of prior research studies in which older ourses were reported to be more tolerant and open to parental participatioo and positive attitudes about family participation in patient care than younger ourses. In these prior studies (Coyne, 1995; Brown & Ritchie, 1990; Seidl, 1969; Gill, 1993) positive attitudes were associated with increased oumber of years of nursing experience. Additionally, oursing literature indicates that certain oursing specialties, such as pediatrics may allow more opportunity and expectatioo for interactioo with family members. The research literature also reports that ourses who are married and have a family, especially if ooe or more of their family members have been hospitalized perceive themselves as having more accepting attitudes towards family involvement. Finally, some ourse researchers have reported that higher levels of educatioo are associated with viewing the family's participation as important to patient recovery (Callery, 1997;

Young, 1992; Chesla, 1996; Coyne, 1995; Brown & Ritchie, 1990; Seidl, 1969; Gill, 1993).

The sample distribution may offer some insight as to why there was no evidence linking nursing specialty to preferences towards family-oriented patient care. At least half of the sample listed critical care nursing as their specialty and the fast pace, restrictive visiting hours, and the nature of the patient's illness may deter nurses from engaging in interactions and involvement with patients' families. However, the participants in this study endorsed family focused care to a large extent.

Recommendations

Implications of the Study

The results of this study point out several factors to consider when approaching patients in medical settings as families. When medical diagnoses become a part of the family, it is important to recognize the position nurses play in the lives of patients and their families. A family-oriented nursing role was shown to be positively associated with perceptions of competence in interacting and intervening with patients' families. This suggests that nurses can be valuable collaborators within an organization that is not a therapy system. An alignment by medical family therapists with nurses is crucial in designing interventions that both include family members in healthcare and treat families as agents of care.

The findings on certain hypotheses suggest that nurses' perceptions of organizational support to involve families in patient care are a complex matter. This further emphasizes the impact of a system care delivery in which hierarchical power, competition, conflicting beliefs, and economic issues affect both patients and families.

Furthermore, the opportunity to collaborate with family specialists was reported as an infrequent occurrence within the medical setting. This has implications for building a stronger alliance within medical settings to raise awareness that families can be important system members in the delivery of healthcare. Family therapists are no looger turning away from a complex medical system and are recognizing that success in working with disease in a family system requires initiating and maintaining relationships with healthcare workers.

Clarifying the nature of the work each ourse is doing in relatioo to patients and their families is needed to facilitate respect and interest in alternative treatment methods and approaches. The results of this study suggest that although styles of family involvement differ among staff nurses; the primary recipient of staff oursing care is the individual patient. Although staff ourses involve families primarily in response to the needs of the their patients, there is strong evidence of their commitment to involve families in patient care. Staff ourses in this study reinforce the view of family nursing theory that family focused care is embraced as a compooent of nursing. However, in order to strengtheo the focus on family, the challenge arises to integrate family theory and nursing practice in order to build upon and acquire the skills and thinking patterns oecessary to obtain positive patient/family outcomes.

Limitations of the Study

There were a oumber of limitations inherent in this study concerning instrumentation, data analyses, and the nature of the sample. Considerable effort was made to select instruments with stroog records of technical validatioo to assess the variables in this study; however, nooe were discovered that were domain specific to

family nursing in the areas of assessing preferred styles of family involvement, perceptions of family self-efficacy, and perceptions of organizational support to include families in patient care.

The decision to develop an instrument to assess these areas was deemed necessary in order to assess the cognitions and perceptions of nurses working with the families of patients. In creating a self-efficacy scale, the work of Bandura (1977) and Pajares (1997) provided a long history of research in self-efficacy measurement and was invaluable in evaluating the construct validity of the FSES. However, there was not the wealth of research evidence to insure the accurate representation of styles of nurse/family involvement and nursing organizational support to work with families with any particular theoretical constructs, rather there were a variety of different theories and practice guidelines depicted in the family nursing literature (Friedman, 1998; Wright & Leahey, 1999; Whall, 1999; Friedemann, 1999).

A panel of nursing experts was utilized to evaluate the face validity of the subscales. Although the panel did judge that these scales did assess the required constructs, these are still perceptions and not representative of the strongest construct validity. It is hoped that through further testing, these subscales will achieve further validity and reliability. Additionally, the instruments used in this study were entirely self-report. Researchers have studied the validity of self-report data and have identified two areas of concern: the ability to provide accurate information and the truthfulness of responses. Self-report responders have also shown evidence of the halo effect, which suggests that they may inflate aspects of their behavior (Wentland & Smith, 1993; Aaker, Stayman, & Vezina, 1988). Given these concerns, Bradburn and Sudman (1988) suggest

that to increase the validity of self-report questionnaires, the following conditions be met: the information should be known, clearly phrased, refer to receot activities, warrant serious responses, and pose no threat to the respoodent. Although the surveys were anonymous, the subjects in this study may have perceived exploring ourse/family styles of involvement and self-efficacy as evaluative of their professionalism, thereby prompting them to report their best performance and/or behavior.

Pajares (1997), in his article about the current directions in self-efficacy research, pointed out that research findings have struggled with differentiating between outcomes related to self-efficacy and outcomes related to numerous other expectancy and/or motivation concepts. Additionally, the development of efficacy assessments bas been plagued by levels of generality that are not related enough to the functional domain. In the absence of more specific criteria and associated tasks or actions, research findings can become obseure and problematic. The possibility that self-efficacy assessments may be measuring other evaluative and/or motivational coocepts suggests that even though great care was taken in designing the family self-efficacy assessment scale, the question arises as to whether this instrument was task-specific enough to accurately capture the domain of ourses' involvement with families of patients.

The limited magnitude of the associatioo between ourses' self-efficacy and nurses' style of family involvement was less encouraging. Bandura (1982) identified some of the factors that could affect the strength of the relationship between self-efficacy judgments and related behaviors. Relevant to this study are: misjudgments about the task, unknown situational constraints that influence the action, faulty performance

assessments, lack of self-knowledge, and other influential factors that discourage action despite perceptions of self-efficacy.

The sampling frame for this study was generated from a list of all nurses employed by the participating hospital. Although all the staff nurses employed by the hospital were afforded an opportunity to participate, it was not a random selection process and therefore was not completely representative of the staff ourse populatioo within the United States. Furthermore, there may have been a self-selection bias in that it could be argued that the ourses who chose to respond to the questionnaire did so because of a greater interest in families or because they felt more competent in dealing with families.

Finally, the data analytic methods used in this study may have comprised was able to represent the data adequately, however, the regression models used with the GSES, RBSE, and POSS displayed several assumption violations (constant variance, outliers, response scaling, curvilinearity) that required a curvilinear adaptation of the linear regression analyses of the data. Although these subsequent analyses are acceptable and reasonable, they demonstrate that the relationships between these factors are very complex and not simply evaluated. It suggests that the measurement of self-efficacy, as explained by Bandura (1988) and Pajares (1997), is fraught with other sources of potential influence.

Suggestions for Future Study

The results of this study suggest that a number of research issues be addressed in future investigations. First, a significant finding in this study that is consistent with the prevalent belief of family nursing theorists (Friedemann, 1999;

Hanson & Boyd, 1996; Wright & Leahey, 1999) was that nurses perceived that they had a primary role with patients' families. This is important to realize as healtheare delivery becomes increasingly collaborative and complex. It appears that staff nurses not only embraced an aetive role with family members but also judged themselves highly competent in dealing with them. Given that staff nurses in this study rated their abilities to interact and intervene with family members higher than the midpoint of the scale suggests that further study on how these skills developed and/or were taught to staff nurses would be important towards understanding why they have such a high estimate of their competence without the specialized training provided in family nursing programs. Furthermore, it would be worthwhile for medieal and nursing family theorists to discover more precisely how the staff nurse assesses the family's ability to collaborate and participate in the care and how the nurse, practicing either an individual, patient oriented style of care, or a more family-focused style of care directs family participation.

Second, tbe results of this study confirm that the general focus of the staff nurse is on the patient first, with the family seen as a context for individual patient care. This supports the nursing typologies proposed by Hanson and Boyd (1996) and Friedman, (1998) whieh defined nursing work with families within the context of influencing the patient's health. The finding that educational level was not significant suggests that the influence of graduate level training on style of family involvement need to be explored further. Since nursing thcorists have suggested that the nursing of families requires greater training and knowledge (Wright & Leahey, 1999; Whall & Fawcett, 1991), further study is needed to delineate when and if the nurse makes a transition from

working with the family in cootext of the patient's care to working with the family as the care agent.

Third, further research on the validation and refioement of the Family Self-Efficacy Scale (FSES) is oeeded. Future research efforts sbould explore the performance of particular items in terms of the weights of items to reflect item performance and the interpretation of the item by the respondent. Construct validatioo should continue to be established across specific nursing specialties and units, in an effort to contextualize family self-efficacy according to the staff nurse's primary domain and the demands of that work eovironment.

Fourth, the relationship between perceptions of nurse family self-efficacy and perceptions of the family members index of involvement should be examined in future research. It must be determined whether measures of ourse family self-efficacy and their preferences for family-oriented care can predict actual reports of greater family involvement within the bealthcare process. Subsequent investigations of the relationship between ourse family self-efficacy and observable family inclusion in patient care should include measures of the types of family engagement behaviors and the frequency of their occurrence.

Finally, this study suggests that future research and educational efforts should be directed to further refiniog the complimentary models of family therapy, interpersonal nursing theory, and family systems oursing theory within medical family therapy and nursing educatioo and practice. Although some nursing theorists (Whall & Fawcett, 1991; Wright and Leahey, 1999; Vosburgh & Simpson, 1993; Forchk & Dorsay, 1995) have utilized family systems theory to compare and conceptualize oursing practice with

families this study suggests that the role of the medical family therapist seems to have been relegated to the staff nurse and/or unit social worker. The frequent identification hy staff nurses in this study of their family specialist for their unit and hospital was a social worker highlights the need for further investigation into the roles of all healthcare professionals who are working together to integrate patient and family healthcare.

Summary

This chapter has provided a discussion of the results and recommendations emanating from a study of the influence of general self-efficacy, role hreadth self-efficacy, family self-efficacy, and perceptions of organizational support on staff nurses' style of family involvement with families of patients. The implications to be drawn from the study results were discussed, and directions were suggested for future investigations on this topic. The findings of this study reinforce the conclusions of prior nursing researcb about nurses' involvement with families, that the scope of family nursing practice encompasses all nurses who have access to patients' family members and that there is a tradition among ourses to view the individual patient as the center of nursing care with the family as a resource or stressor (Friedemann, 1999; Hanson & Boyd, 1996; Wright & Leahey, 1999). The unique contribution of the present study lies in the attempt to verify this preference among staff nurses and evaluate their perception of competence within this role. The responses of this sample of staff nurses seemed to affirm a preference towards family focused patient care and high levels of efficacy in interacting and intervening with family members. It is hoped that these efforts stimulate further researcb on understanding essential family connections and interfaces within the healthcare system.

APPENDIX A
LETTER TO PARTICIPANTS

Dear Registered Nurse:

Nursing roles have changed over the years and we are faced with greater challenges to maintain our practice and professional goals! For most, we depend upon our own determination and perseverance to cope with the increasing demands and responsibilities in today's workplace.

I have been a registered nurse for 27 years and I have noticed that more than any other health professional, nurses are being tasked with helping families traverse the maze of healtheare. To me this means greater demands on my time, skills, and organizational abilities. As I have tried to respond to the greater expectations and demands in my nursing career, I have found that healtheare managers seem ill-informed about staff nurses' opinions coneerning family involvement in patient care.

When I decided to seek my doctorate degree, I wanted my research to give a voiee to nurses about their ideas and opinions concerning their role with the family memhers of their patients. **Please respond to this questionnaire based apon your aetual nursing praetice rather than anrsing philosophy.**

Your name was randomly chosen by Shands' Nursing administration to partieipate in this study. *Please note!* Your participation in this research project is completely voluntary and the questionnaires are anonymous and strietly confidential.

I hope that you will fill out the questionnaire and return it as soon as possihle in the return envelope provided through inter-department mail on your unit. I have enelosed a free magnet to tell you how important you are to others and to show my appreciation for your time and effort.

If I have not received the questionnaire from you in 2 weeks, I will send a reminder notiee to your unit. A numher on the return envelope identifies you for this purpose. When I receive the questionnaire, I will ebeck off the number and throw the envelope away. Should you have any questions about the questionnaire, please eall me at (352) 392-4541 extension 242 or use my email: cmb@chfm.ufl.edu. I welcome your questions and/or comments.

I would like to personally thank you for your help and interest in assisting me in this research effort.

Sincerely,

Cathy Burns, RN, MA, PhD Candidate
University of Florida

APPENDIX B
DEMOGRAPHIC DATA SHEET

NURSE/FAMILY RELATIONSHIPS RESEARCH STUDY

Demographic Data- (Please write in your answers)

1.	Age?	
2.	Gender?	
3.	Race?	
4.	Marital status?	
5.	Nursing specialty?	
6.	Nursing degree held?	
7.	Other educational degree held?	
8.	Total number of years of experience in nursing?	
9.	Present nursing job?	
10.	How long in this position?	
11.	Has a family member of yours ever been hospitalized?	
12.	If, yes to question #10, what was the relationship of that family member?	

APPENDIX C
GENERAL SELF-EFFICACY SCALE

GSES

Please read each statement below very carefully and remember that there are no right or wrong answers. *Tell me how true or false each statement is for you.*

1	I can always manage to solve difficult problems if I try hard enough.	F T T T
2	If someone opposes me, I can find the ways and means to get what I want.	F T T T
3	I am certain that I can accomplish my goals.	F T T T
4	I am confident that I could deal efficiently with unexpected events.	F T T T
5	Thanks to my resourcefulness, I can handle unforeseen situations.	F T T T
6	I can solve most problems if I invest the necessary effort.	F T T T
7	I can remain calm when facing difficulties because I can rely on my coping abilities.	F T T T
8	When I am confronted with a problem, I can find several solutions.	F T T T
9	If I am in trouble, I can think of a good solution.	F T T T
10	I can handle whatever comes my way.	F T T T

APPENDIX D
ROLE BREADTH SELF-EFFICACY MEASURE

RBSE

Please read each statement below very carefully and use the following scale to answer as honestly as you can. Remember that you can circle any number from 1 to 6.

Not at all confident **Very Confident**

"How confident would you feel . . ."

1	Analyzing a long-term problem in your nursing work area to find a solution?	1 2 3 4 5 6
2	Representing your nursing unit in meetings with nursing administration?	1 2 3 4 5 6
3	Designing new procedures for your nursing unit?	1 2 3 4 5 6
4	Making suggestions to nursing administration about ways to improve the working of your unit?	1 2 3 4 5 6
5	Contributing to discussions about the hospital's strategy?	1 2 3 4 5 6
6	Writing a proposal to spend money in your nursing unit?	1 2 3 4 5 6
7	Helping to set targets/goals in your nursing unit?	1 2 3 4 5 6
8	Contacting people outside the hospital (e.g. home health, support groups, volunteer groups) to discuss problems?	1 2 3 4 5 6
9	Presenting information to a group of colleagues?	1 2 3 4 5 6
10	Visiting people from other departments such as lab, x-ray, dietary, etc. to suggest doing things differently	1 2 3 4 5 6

APPENDIX E
NURSE/FAMILY ROLE FACTORS SCALE

SFIS

(Styles of Family Involvement Subscale)

Directions: On a scale from 1 (not true) to 6 (very true), how do you describe your "NURSING PRACTICE"? ***Remember that you can circle any number between 1 and 6***

1	2	3	4	5	6
Not true		Moderately true			Very true

(1.) I try to complete my work with the patient before the family comes or is absent from the room.

1 2 3 4 5 6

(2.) When my patient's family members are present I view it as an opportunity for teaching the family about the patient's care.

1 2 3 4 5 6

(3.) I believe that family members mean well but they interfere in the patient's progress and the medical staff's efforts to help the patient.

1 2 3 4 5 6

(4.) I teach family members nursing skills so that they can provide nursing care to the patient in my absence.

1 2 3 4 5 6

(5.) I tend to avoid contact and/or interactions with family members if I can.

1 2 3 4 5 6

(6.) I view a supportive listening role with family members as a good use of my nursing time.

1 2 3 4 5 6

SFIS - continued

Directions: On a scala from 1 (not true) to 6 (very true), how do you describe your "NURSING PRACTICE"? *Remember that you can circle any number between 1 and 6*

1 2 3 4 5 6

Not true **Moderately true** **Very true**

(7.) I discuss the individual health care needs of my patient's family members when they are present.

1 2 3 4 5 6

(8.) I form close, meaningful, relationships with the family members of my patients.

1 2 3 4 5 6

(9.) In addition to working with my patient I look forward to working with his/her family members as well.

1 2 3 4 5 6

(10.) I discuss the family members' concerns and fears about my patient with them.

1 2 3 4 5 6

(11.) My primary focus of care is on the family of my patient.

1 2 3 4 5 6

(12.) I interact on a daily basis with the family members of my patients.

1 2 3 4 5 6

POSS[1]

(Perceptions of Organizational Support)

Directions: On a scale from 1 (not true) to 6 (very true), how do you describe your "UNIT WORK SETTING"? Remember that you can circle any number between 1 and 6

1 2 3 4 5 6

Not true **Moderately true** **Very true**

(13.) **My nursing unit allows me enough time, when performing my nursing duties, to involve my patient's family members in their care.**

1 2 3 4 5 6

(14.) **I have a clear understanding from my nurse manager about his/her expectations of my nursing role with the family members of my patients.**

1 2 3 4 5 6

(15.) **My nurse manager provides guidance and/or suggestions to me about appropriate nursing care interventions for patient family members.**

1 2 3 4 5 6

(16.) **At this nursing unit, I am given the opportunity to consult with a 'family specialist' about my concerns with patient's families.**

1 2 3 4 5 6

(17.) **The nurses I work with involve families in the care of their patients.**

1 2 3 4 5 6

(18.) **I discuss family care issues with other nurses on my unit.**

1 2 3 4 5 6

(19.) **On this nursing unit, I have noticed that no one really seems to care whether I address family care needs or not.**

1 2 3 4 5 6

POSS[2]

(Perceptions of Organizational Support)

Directions: On e scais from 1 (not trus) to 6 (very true), how do you dsscribe your "HOSPITAL WORK SETTING"? Remember thet you can circle any number bstwsen 1 end 6

1	2	3	4	5	6
Not trus		Moderateiy trus			Very true

(20.) Ths hospitai rooms ars sst up snd orgenized so thet, when performing my nursing duties, i can invoive my patient'e femily membsrs in thet cers.

1 2 3 4 5 6

(21.) I have s ciesr understanding from hospitai adminietrators ebout thsir expectations of my nursing role with the family members of my patients.

1 2 3 4 5 6

(22.) Thie hospitai provides guidsnce snd/or euggeetione to pstisnt family members ebout eppropriate nursing care interventione.

1 2 3 4 5 6

(23.) This hoepitai hee a 'femily epecisilst' thet consuits with pstient'e familise thst is sveiieble to every nursing unit.

1 2 3 4 5 6

(24.) The physiciene i work with involve familiee in the care of their patients.

1 2 3 4 5 6

(25.) I discuss family cars issues with ths patisnt's doctors.

1 2 3 4 5 6

(26.) Within thie hospital, I have noticed thst hospital edministrators seldom addrsss family cara needs.

1 2 3 4 5 6

FSES

(Family Self-Efficacy Subscale)

Directions: Using the scale from 1 (not confident at all) to 6 (completely confident), answer the questions below.

1 2 3 4 5 6

Not confident — Moderately confident — Completely confident

"How well can you . . . ."

(27.)	Continue your nursing duties without added anxiety/stress when your patient's family member comes in the room?	1 2 3 4 5 6
(28.)	Explain to family members about your patient's disease process and treatment plan?	1 2 3 4 5 6
(29.)	Ask a family member to help you with the basic nursing care of your patient?	1 2 3 4 5 6
(30.)	Tell a family member he/she has to leave the room during a medical procedure?	1 2 3 4 5 6
(31.)	Teach family members nursing skills to provide care to the patient at home in your absence?	1 2 3 4 5 6
(32.)	Assess the needs and identify the problems and concerns of your patient's family members?	1 2 3 4 5 6
(33.)	Interact effectively with family members who are acting angry to reassure them and gain their trust?	1 2 3 4 5 6
(34.)	Devise a nursing intervention for your patient's family member that is based upon your professional nursing education and training?	1 2 3 4 5 6
(35.)	Discuss the needs of your patient's family members with your supervisor?	1 2 3 4 5 6

FSES - continued

Directions: Using the scale from 1 (not confident at all) to 6 (completely confident), answer the questions below.

1 2 3 4 5 6

Not confident Moderately confident Completely confident

"How well can you . . . ."

(36.)	Imitate other nurses' interventions (that you value) with family members?	1 2 3 4 5 6
(37.)	Tell a family member you are their nurse and their needs are as important to you as your patients'?	1 2 3 4 5 6
(38.)	Allow a family member to remain with the patient even though your colleagues do not approve?	1 2 3 4 5 6
(39.)	Counsel distressed family members utilizing techniques and/or skills acquired in your formal nursing training?	1 2 3 4 5 6
(40.)	Teach family members nursing skills to provide care to the patient in the hospital when you are absent?	1 2 3 4 5 6
(41.)	Interact effectively with patient's family members during a busy and stressful day at work?	1 2 3 4 5 6
(42.)	Influence your organization to give you the time you need to meet the nursing needs of patients' family members?	1 2 3 4 5 6
(43.)	Manage your time to meet the unpredictable demands of family members?	1 2 3 4 5 6

REFERENCES

Aaker, D. A., Stayman, D. M., & Vezina, R. (1988). Identifying feelings elicited by advertising, Psychology & Marketing, 5, (1), 1-16.

Allender, C. D., Egan, E. C., & Newman, M. A. (1995). An instrument for measuring differentiated nursing practice. Nursing Management, 26, (4), 42-45.

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. Psychological Review, 84, (2), 191-215.

Bandura, A. (1982). Self-efficacy mechanism in human agency. American Psychologist, 37, (2), 122-147.

Bandura, A. (1986). Social foundations of thought and action: A social cognitive theory. New Jersey: Prentice-Hall.

Bandura, A. (1993). Perceived self-efficacy in cognitive development and functioning. Educational Psychologist, 28, (2), 117-148.

Bates, F. L. & Harvey, C. C. (1975). The structure of social systems. New York: Wiley.

Bell, J. M., Wright, L. M., & Watson, W. L. (1992). The medical map is not the territory; or, "medical family therapy?" Watch your language! Family Systems Medicine, 10, (1), 35-39.

Biddle, B. J. (1986). Recent developments in role theory. In R. H. Turner & J. F. Short (Eds.), Annual review of sociology (pp. 67-92). Palo Alto, CA: Annual Reviews Inc.

Bloch, D. (1986). The family therapists as consultant to health care organizations. In L. Wynne, S. McDaniel & T. Weber (Eds.), Systems consultation: A new perspective on family therapy (pp. 135-150). New York: Guilford.

Brown, J. & Ritchie, J. A. (1990). Nurses' perceptions of parent and nurse roles in caring for hospitalized children. Children's Health Care, 19, (1), 28-36.

Bradburn, N. M. & Sudman, S. (1988). Polls & surveys: understanding what they tell us. San Francisco: Jossey-Bass.

Burt, R. S. (1982). Toward a structural theory of action: network models of social structure, perception, and action. New York: Academic.

Callery, P. (1997). Caring for parents of hospitalized children: A hidden area of nursing work. Journal of Advanced Nursing, 26, 992-998.

Chesla, C. (1996). Reconciling technologic and family care in critical-care nursing. IMAGE: Journal of Nursing Scholarship, 28, (3), 199-203.

Christie-Seely, J. (1984). Working with family in primary care. New York: Praeger.

Cone, J. D. & Foster, S. L. (1996). Dissertations and theses from start to finish: psychology and related fields. Washington D.C.: American Psychological Association.

Corwin, R. G. & Taves, M. J. (1962). Some concomitants of bureaucratic and professional conceptions of the nurse role. Nursing Research, 11, (4), 223-227.

Courtney, R., Ballard, E., Fauver, S., Gariota, M., & Holland, L. (1996). The partnership model: Working with individuals, families, and communities toward a new vision of health. Puhlic Health Nursing, 13, (3), 177-186.

Coyne, I. T. (1995). Parental participation in care: A critical review of the literature. Journal of Advanced Nursing, 21, 716-722.

Craft, M. J. & Willadsen, J. A. (1992). Interventions related to the family. Nursing Clinics of North America, 27, (2), 517-540.

Craven, K. O. & Froman, R. D. (1993). Development of a pediatric skill self-efficacy scale. Journal of Nursing Measurement, 1, (2), 125-133.

Denham, S. A. (1995). Family routines: A construct for considering family health. Holistic Nursing Practice, 9, (4), 11-23.

Doherty, W. J. & Baird, M. A. (1986). Family therapy and family medicine: toward the primary care of families. New York: Guilford.

Doherty, W. J. & Campbell, T. L. (1988). Families and health. Newhury Park, CA: Sage Publications.

Doherty, W. J., McDaniel, S. H., & Hepworth, J. (1994). Medical family therapy: An emerging arena for family therapy. Journal of Family Therapy, 16, 31-46.

Elizur, Y. (1996). Involvement, collaboration, and empowerment: A model for consultation with human-service agencies and the development of family-oriented care. Family Process, 35, 191-210.

Eyres, P. J. (1972). The role of the ourse in family-centered nursing care. Nursing Clinics of North America, 7, (1), 27-39.

Forchuk, C. & Dorsay, J. P. (1995). Hildegard peplau meets family systems nursing: Innovation in theory-based practice. Journal of Advanced Nursing, 21, 110-115.

Ford, M., Laschinger, H. S., Laforet, Y., Ward, C., & Foran, S. (1997). The effect of a clinical practicum oo undergraduate oursing students' self-efficacy for community-hased family oursing practice. Journal of Nursing Education, 36, (5), 212-219.

Francke, A. L., Lemmens, A. B., Abu-Saad, H. H., & Grypdoock, M. (1997). Nurses' perceptions of factors influencing the use of a pain program. Journal of Pain Symptom Management, 14, (5), 300-310.

Friedemann, M. (1999). The coocept of family oursing. In G. D. Wegner & R. J. Alexander (Eds.), Readings in Family Nursing (pp.13-22). New York: Lippincott.

Friedman, M. M. (1998). Family oursing: research, theory, and practice. Stanford, CT: Appletoo & Lange.

Gill, K. M. (1993). Health professionals' attitudes toward parent participation in hospitalized children's care. Children's Health Care, 22, (4), 257-271.

Greenhlatt, M., Levinson, D. J., & Williams, R. H. (1957). The patient and the mental hospital. Glencoe, Ill: Free Press.

Greiner, D. S. (1984). Hospitals and outpatient clinics. In M. Berger, G. Jurkovic & Associates (Eds.), Practicing family therapy in diverse settings (pp. 247-270). San Francisco: Jossey-Bass.

Gross, N., Mason, W. S., & McEachern, A. W. (1958). Exploration in role analysis. New York: Wiley.

Hardy, M. E. & Cooway, M. E. (1978). Role theory: perspectives for health professionals. New York: Appletoo-Century-Crofts.

Hanson, S. M. H. & Boyd, S. T. (1996). Family health care oursing: theory, practice, and research. Philadelphia, PA: F.A. Davis Company.

Hayes, E. (1998). Mentoring and self-efficacy for advanced oursing practice: A philosophical approach for ourse practitioner preeeptors. Journal of American Academy of Nurse Practitiooers, 10, (2), 53-57.

Imber-Black, E. (1988). Families and larger systems. New York: Guilford.

Itano, J. K., Warren, J. J., & Ishida, D. N. (1987). A comparison of role eooceptions and role deprivatioo of baccalaureate students in oursing participating in a

preceptorship or a traditional clinical program. Journal of Nursing Education, 26, (2), 69-73.

Jacques, R. (1993). Untheorized dimensions of caring work: Caring as a structural practice and caring as a way of seeing. Nursing Administratioo Quarterly, 17, (2), 1-10.

Johnson, S. K., Craft, M., Titler, M., Halm, M., Kleiber, C., Montgomery, L. A., Megivern, K., Nicholson, A., & Buckwalter, K. (1995). Perceived changes in adult family members' roles and responsibilities during critical illness. IMAGE: Journal of Nursing Scholarship, 27, (3), 238-243.

Ketefian, S. (1985). Professional and bureaucratic role conceptions and moral behavior among ourses. Nursing Research, 34, (4), 248-253.

Kramer, M., McDonnell, C., & Reed, J. L. (1972). Self-actualization and role adaptation of baccalaureate degree ourses. Nursing Research, 21, (2), 111-123.

Kushnir, T, Rabin, S., & Azulai, S. (1997). A descriptive study of stress management in a group of pediatric oncology nurses. Cancer Nursing, 20, (6), 414-421.

Laitinen, P. & Isola, A. (1996). Promoting participation of informal caregivers in the bospital care of the elderly patient: Informal caregivers' perceptions. Journal of Advanced Nursing, 23, 942-947.

Lawrence, J. A., Wearing, A., J., & Dodds, A. E. (1996). Nurses' representations of the positive and negative features of oursing. Journal of Advanced Nursing, 24, 375-384.

Lengacher, C. A. (1994). Effects of professional development seminars on role conception, role deprivation, and self-esteem of generic baccalaureate students. Nursing Connections, 7, (1), 21-34.

Levinson, D. J. (1959). Role, personality, and social structure in the organizational setting. The Journal of Abnormal and Social Psychology, 58, 170-180.

Luciano, K. B. (1972). Staff development: Toward the implementation of family-centered care. Nursing Clinics of North America, 7, (1), 75-82.

Madorin, S. & Iwasiw, C. (1999). The effects of computer-assisted instruction on the self-efficacy of baccalaureate nursing students. Journal of Nursing Education, 38, (6), 282-285.

Meleis, A. I. (1975). Role insufficiency and role supplementation: A conceptual framework. Nursing Research, 24, (4), 264-271.

McDaniel, S. H., Hepworth, J. & Doherty, W. (1995). Medical family therapy with somatizing patients: The co-creation of therapeutic stories. In R. Mikesell, D.

Lusterman, & S. McDaniel (Eds.), Intergrating family therapy: Handbook of family psychology and systems theory (p. 378). Washington, DC: American Psychological Association.

Minehan, P. L. (1977). Nurse role conception. Nursing Research, 26, (5), 374-379.

Nichols, M. P. & Schwartz, R. C. (1998). Family therapy concepts and methods. Massachusetts: Allyn & Bacon.

Ozer, E. M. & Bandura, A. (1990). Mechanisms governiog empowerment effects: A self-efficacy analysis. Journal of Personality and Social Psychology, 58, (3), 472-486.

Parker, S. K. (1998). Enhancing role hreadth self-efficacy: The roles of joh enrichment and other organizatiooal interventions. Journal of Applied Psychology, 83, (6), 835-852.

Pajares, F. (1997). Current directions in self-efficacy research. In M. Maehr & P. R. Pintrich (Eds.), Advances in motivation and achievement (pp. 1-49). Greenwich, CT: JAI Press.

Porter, L. S. (1979). Health care workers' role cooceptions and orientatioo to family-centered child care. Nursing Research, 28, (6), 330-337.

Richardson, B. L. (1993). Development of an instrument to measure the self-efficacy of critical care staff ourses. (Doctoral dissertation, University of Virginia).

Robinson, C. A. (1994). Nursing interventions with families: A demand or an invitatioo to change? Journal of Advanced Nursing, 19, 897-904.

Robinson, C. A. (1996). Health care relationships revisited. Journal of Family Nursing, 2, (2), 152-173.

Roooey, R.A., & Osipow, S. H. (1992). Task-specific occupational self-efficacy scale: The development and validatioo of a prototype. Journal of Vocational Behavior, 40, 14-32.

Schwartzman, J. (Ed.) (1985). Families and other systems: the macrosystemic cootext of family therapy. New York: Guilford.

Schwarzer, R., Bjer, J., Kwiatek, P., & Schroder, K. (1996). The assessment of optimistic self-beliefs: Comparisoo of the german, spanish, and chinese versions of the general self-efficacy scale. Berlin, Germany: Authors. Retrieved March 12, 2001 from the World Wide Web: http://www.fu-berlin.de/gesund/gesu_engl/lingua5.htm

Schwarzer, R. (1997). Optimistic self-beliefs: Assessment of general perceived self-efficacy in 14 cultures. World Psychology, 3, (1-2), 177-190. Retrieved March 28, 2001 from the World Wide Web: http://www.userpage.fu-berlin.de/~health/world14.htm

Schwarzer, R. & Jerusalem, M. (2000). General perceived self-efficacy. Berlin, Germany: Authors. Retrieved March 12, 2001 from the World Wide Web:http://www.fu-herlin.de/gesund/skalen/Language.../hauptteil_general_perceived_self-efficac.htm

Seidl, F. W. (1969). Pediatric oursing personnel and pareot participation: A study in attitudes. Nursing Research, 18, (1), 40-44.

Shah, H. S., Bruttomess, K. A., Sullivan, D. T., & Lattanzio, J. (1997). An evaluatioo of the role and practices of the acute-care ourse practitioner. AACN Clinical Issues: Advanced Practice in Acute and Critical Care, 8, (1), 147-155.

Sherer, M. & Maddux, J. E. (1982). The self-efficacy scale: Constructioo and validation. Psychological Reports, 51, 663-671.

Spratley, E., Johnson, A., Sochalski, J., Fritz, M., & Spencer, W. (2000). The registered nurse population: Findings from the national sample survey of registered ourses. United States Department of Health and Human Services: Authors. Retrieved June 28, 2002 from the World Wide Web: http://www.hhpr.hrsa.gov/healthworkforce/nsurvey/

Talotta, D. (1990). Role cooceptions and professional role discrepancy amoog baccalaureate oursing students employed as nurse's aides. IMAGE: Journal of Nursing Scholarship, 22, (2), 111-115.

Taunton, R. L. & Otteman, D. (1986). The multiple dimensions of staff nurse role cooceptioo. Journal of Nursing Administration, 16, (10), 31-37.

Tipton, R. M. & Worthington, E. L. (1984). The measurement of generalized self-efficacy: A study of construct validity. Journal of Personality Assessment, 48, (5), 545-548.

Tooges, M. C., Rothstein, H., & Carter, H. K. (1998). Sources of satisfaction in hospital nursing practice: A guide to effective joh design. Journal of Nursiog Administration, 28, (5), 47-61.

Verschuren, P. J. M. & Masselink, H. (1997). Role concepts and expectations of physicians and nurses in hospitals. Social Science Medicine, 45, (7), 1135-1138.

Voshurgh, D. & Simpson, P. (1993). Linking family theory and practice: A family oursing program. IMAGE: Journal of Nursing Scholarship, 25, (3), 231-235.

Wentland, E. & Smith, K. W. (1993). Survey responses: an evaluatioo of their validity. San Diego: Academic Press.

Whall, A. L. (1999). The family as the unit of care in nursing: A historical review. In G. D. Wegner & R. J. Alexander (Eds.), Readings in Family Nursing (pp. 3-12). New York: Lippincott.

Whall, A. L., & Fawcett, J. (1991). Family theory development in nursing: state of the science and art. Philadelphia: F. A. Davis Company.

Wimett, L. C. H. (1992). Perceived self-efficacy of medical/surgical registered nurses. (Doctoral dissertation, University of Missouri).

Winship, C. & Mandel, M. (1983). Roles and positions: A critique and extension of the blockmodeling approach. In S. Leinhardt (Ed.), Sociological Methodology (pp. 314-344). San Francisco: Jossey-Bass.

Wright, L. M. & Leahey, M. (1988). Nursing and family therapy training. In H. Little, D. Breunlin, & R. Schwartz (Eds.), Handbook of family therapy and training and supervision (pp.278-289). New York: Guilford.

Wright, L. M. & Leahey, M. (1999). Trends in nursing of families. In G. D. Wegner & R. J. Alexander (Eds.), Readings in Family Nursing (pp. 23-33). New York: Lippincott.

Wynne, L. C., McDaniel, S. H., & Weber, T. T. (1987). Professional politics and the concepts of family therapy, family consultation, and systems consultation. Family Process, 26, 153-166.

Young, J. (1992). Changing attitudes towards families of hospitalized children from 1935 to 1975: A case study. Journal of Advanced Nursing, 17, 1422-1429.

BIOGRAPHICAL SKETCH

Cathy Marie Byrd Burns was born in Dayton, Ohio, in 1952, the youngest of five children. Her childhood spent as an "Army Brat" prepared her for a career with the United States Army. She graduated from the University of Mississippi School of Nursing in 1974 and joined the Uoited States Army Nurse Corps on active duty for 8 years and remained in the reserves for 22 years. When she was statiooed in West Germany, Cathy obtained her Master of Educatioo in counseling psychology in 1979 and performed the duties of group and family therapist with soldiers and their families in the United States Army. In 1980, while living in West Germany, she met and married Richard R. Burns, a Special Forces soldier and together with their two children Erin and Shane spent 8 more years in West Germany, a country they both grew to love and respect. Upoo their return to the United States in 1988, they moved to Gainesville, Florida, and Cathy resumed her oursing career with a focus on mental health counseling and addictions treatment. She entered the University of Florida to pursue further training in marriage and family counseling and began the doctoral program in 1993.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Ellen Amatea, Chairperson
Professor of Counselor Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Silvia Echevarria-Doan,
Associate Professor of Counselor Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

M. David Miller
Professor of Educational Psychology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Lovetta Smith
Visiting Assistant Professor of Nursing

This dissertation was submitted to the Graduate Faculty of the College of Education and to the Graduate School and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

December, 2002

Dean, College of Education

Dean, Graduate School